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CURRENT AWARENESS IN HEALTH EDUCATION

Part 1, 81-0151 – 81-0300
Part 2, 81-0301 – 81-0448

U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
CENTER FOR HEALTH PROMOTION AND EDUCATION
Atlanta, Georgia 30333

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CURRENT AWARENESS IN HEALTH EDUCATION

JULY 1982, Part 1

81-0151–81-0300

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INTRODUCTION

Current Awareness in Health Education (CAHE) is published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents acquired and selected by the Center. CAHE also contains descriptions of programs in health education. These descriptions are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources. To make the information in CAHE timely, only documents published or programs of relevance since 1977 are included.

Copies of each document and supporting documentation for each program description are stored in the Center's permanent collection. Users of CAHE are urged to consult local public, medical, and university libraries for individual copies. Sufficient information is provided in the citations to enable users to locate copies or to contact programs.

All persons receiving CAHE are invited to contribute copies of pertinent documents and descriptions of relevant programs for possible inclusion. The Center also welcomes any comments on CAHE and suggestions to improve its usefulness. Write or call:

Centers for Disease Control
Center for Health Promotion and
Education
Attn: Current Awareness in Health
Education
Building 14
Atlanta, GA 30333
(404) 329-3235
FTS 236-3235

Tearsheets for submitting program documents and descriptions of relevant programs are provided on pages vii-viii.

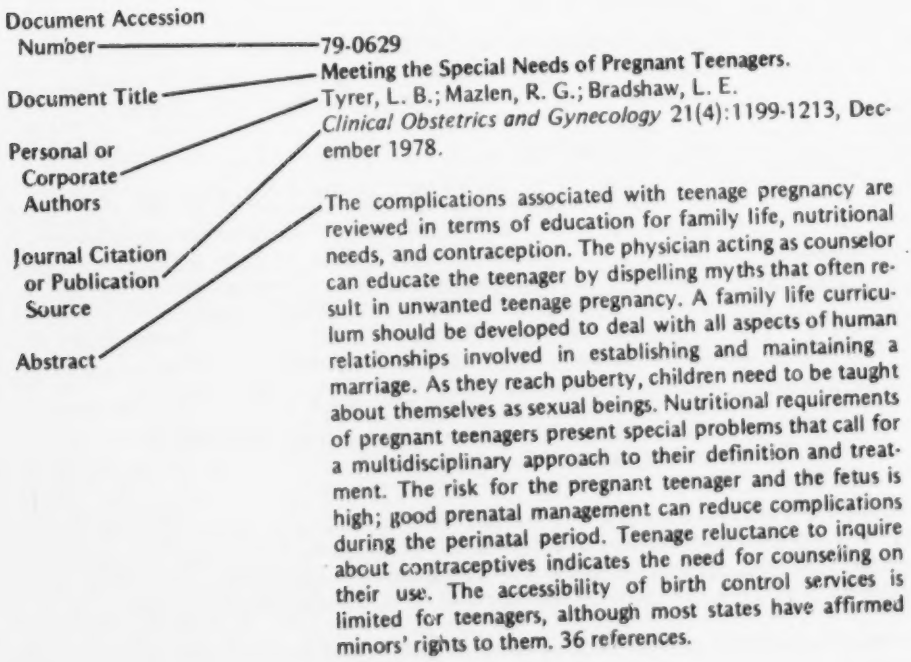
HOW TO USE CAHE

CAHE contains two types of records: informative abstracts of published literature and descriptions of ongoing programs. These records are arranged in chapters according to their major subject area. Chapter headings are used to group items generally related and include: Community Health Education; Health Education in Occupational Settings; Health Education Methodology; Patient Education; Professional Education and Training; Regulation, Legislation, and Administration; Research and Evaluation; Risk Reduction; School Health Education; Self-Care; and Sex Education. The chapter headings reflect active areas in health education as well as major interests of the Center for Health Promotion and Education. To locate specific items of interest, users are encouraged to use the extensive Subject, Author, and Program Title indexes found in the back of each issue.

Within each chapter, citations and abstracts of documents appear first, followed by descriptions of programs. Abstracts with their citations are arranged in alphabetical order by the primary author's name, and descriptions of programs are arranged in alphabetical order by the title of the program.

Each document and program description has a unique accession number. Accession numbers of documents consist of a two-digit prefix indicating the year of acquisition by CAHE and a four-digit number indicating the publication sequence of the document. For example, 79-0022 indicates the 22nd document acquired by CAHE in 1979. Program accession numbers have a similar format with a "P" added following the year to indicate program, e.g., 79P-0025 indicates the 25th item acquired by CAHE in 1979, and that the item is a program.

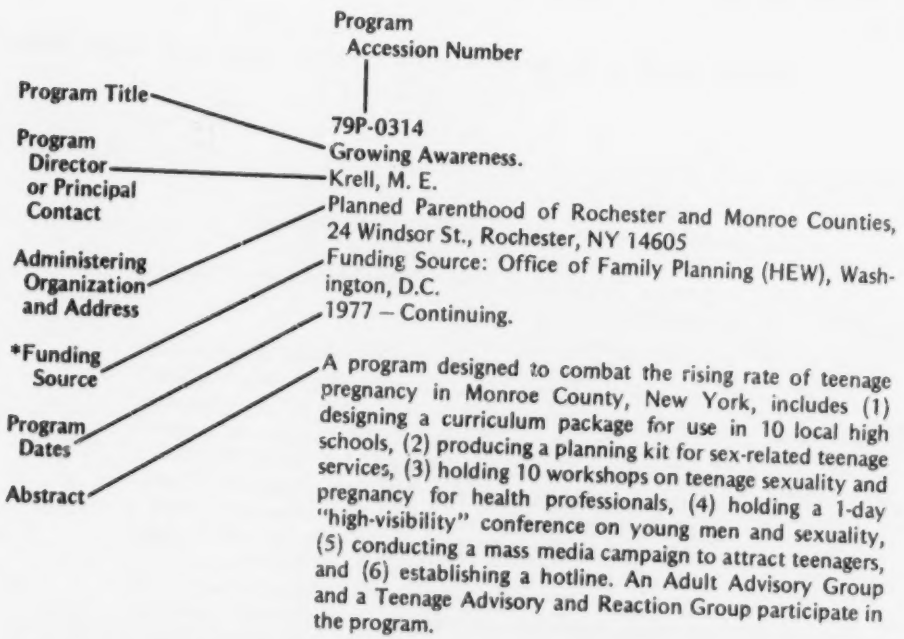
Each document is uniformly identified and described by the elements labeled in the sample below:


Document Accession Number
Document Title
Personal or Corporate Authors
Journal Citation or Publication Source
Abstract
79-0629
Meeting the Special Needs of Pregnant Teenagers.
Tyrer, L. B.; Mazlen, R. G.; Bradshaw, L. E.
Clinical Obstetrics and Gynecology 21(4):1199-1213, December 1978.
The complications associated with teenage pregnancy are reviewed in terms of education for family life, nutritional needs, and contraception. The physician acting as counselor can educate the teenager by dispelling myths that often result in unwanted teenage pregnancy. A family life curriculum should be developed to deal with all aspects of human relationships involved in establishing and maintaining a marriage. As they reach puberty, children need to be taught about themselves as sexual beings. Nutritional requirements of pregnant teenagers present special problems that call for a multidisciplinary approach to their definition and treatment. The risk for the pregnant teenager and the fetus is high; good prenatal management can reduce complications during the perinatal period. Teenage reluctance to inquire about contraceptives indicates the need for counseling on their use. The accessibility of birth control services is limited for teenagers, although most states have affirmed minors' rights to them. 36 references.

The distributor from which a document cited in CAHE is available to the public may be given as the last element in the citation. The most commonly cited distributors and their acronyms are listed below. Price information may be obtained from the supplier at the address given by specifying the order or stock number of the document and the form, hard copy or microfiche, desired. If the document is available from a distributor other than those listed, such as directly from the author, the address of that alternate distributor is provided.

Available from GPO:	Document is sold by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, in hard copy.
Available from ERIC:	Document is available from the Educational Resources Information Center Document Reproduction Service (EDRS), P.O. Box 190, Arlington, VA 22210, in hard copy or microfiche.
Available from NTIS:	Document may be purchased from the National Technical Information Service, U.S. Department of Commerce, Springfield, VA 22161, in hard copy or microfiche.

Each program description is uniformly identified and described by the elements labeled in the sample below:


Program Accession Number
Program Title
Program Director or Principal Contact
Administering Organization and Address
*Funding Source
Program Dates
Abstract
79P-0314
Growing Awareness.
Krell, M. E.
Planned Parenthood of Rochester and Monroe Counties, 24 Windsor St., Rochester, NY 14605
Funding Source: Office of Family Planning (HEW), Washington, D.C.
1977 – Continuing.
A program designed to combat the rising rate of teenage pregnancy in Monroe County, New York, includes (1) designing a curriculum package for use in 10 local high schools, (2) producing a planning kit for sex-related teenage services, (3) holding 10 workshops on teenage sexuality and pregnancy for health professionals, (4) holding a 1-day "high-visibility" conference on young men and sexuality, (5) conducting a mass media campaign to attract teenagers, and (6) establishing a hotline. An Adult Advisory Group and a Teenage Advisory and Reaction Group participate in the program.

CAHE contains three indexes. They are: (1) Author, which contains the names of personal and corporate authors of documents and directors of programs; (2) Subject, which contains subject descriptors, including geographic location, for both documents and programs; and (3) Program Title, which contains names of programs that are either mentioned in documents or detailed in program descriptions.

*The funding source is specified if the program receives funds from institutions other than the administering organization.

PROGRAM DATA SHEET

The Center for Health Promotion and Education is collecting information about current health education programs for use in *Current Awareness in Health Education* and in analyzing program trends in the field. A program may provide identification, public awareness, coordination, training, demonstration, etc.

If you wish to share your program efforts with other health education professionals, please complete the form below, being as specific as possible in providing information.

We greatly appreciate your taking the time to share your experience with us.

---

1. Program Identification:

   Official Title of Program or Grant and Grant No: _____

   Official Name of the Organization Conducting the Program: _____

   Address of the Organization:

   _____ _____ _____ _____
   street city state zip code

   Program Director: _____ _____ _____ _____ _____
   name title telephone area code number

   Principal Contact: _____ _____ _____ _____ _____
   (if different from Program Director) name title telephone area code number

   Beginning Date of Program: _____ Ending Date, If known: _____

2. Funding Source for Your Program:

   Please provide the Name(s) and Location(s) (City, State) of Funding Source(s):

   _____

   _____

   _____

3. Focus of Program: _____Administration _____Community Health Education _____Health Education Methodology

   _____Nutrition Education _____Occupational Health Education _____Patient Education

   _____Professional Training Programs _____Research and Evaluation _____Risk Reduction _____Sex Education

   _____School Health Education Other _____

4. Target Population(s): _____

5. Purpose of Program: Please describe the primary purpose of your program

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Publications/Information Materials: Please send copies of any publications or material describing your program, if available, or give complete citation (author, title, date, publisher). If no publications exist or are planned, please state how further information may be obtained.

   _____

   _____

   _____

   _____

   _____

THANK YOU.

(Please cut along dotted line)

Name, Title of Person Submitting Program Information

Organization

Street

City, State, Zip Code

Phone

Fold Here First

Place stamp here

Centers for Disease Control
Center for Health Promotion and Education
ATTN: Current Awareness in Health Education
Atlanta, GA 30333

Fold Here

(Please cut along dotted line)

Tape

COMMUNITY HEALTH EDUCATION

81-0151
American Hospital Association-Bureau of Health Education Health Education Project-Reimbursement Forum Proceedings, October 25, 1979, American Hospital Association.
American Hospital Association, Chicago, Ill. Center for Health Promotion.
Atlanta, Ga., Center for Disease Control, Bureau of Health Education, 123 p., April 1980.

One of the major findings that emerged from contractual activities between the Bureau of Health Education and the American Hospital Association is that a lack of financial expertise on the part of professionals concerned with health education is a barrier to implementing health education programs in hospitals. This impediment extends from lack of technical skill in appropriate budgeting techniques to philosophical disagreements among interest groups involved in health education over the entire structure of third-party financial mechanisms and financial incentives in the health care industry. Previous work had also identified that practitioners in the field of patient education lack knowledge about which health education activities are currently reimbursable. A portion of contract activities was therefore designed to address the topics of budgeting, reimbursement, and financing. The reimbursement forum documented by these proceedings was designed to address these identified needs in a public exchange of views.

81-0152
The Important First Trimester: An Educational Approach.
Cranston, C. S.
Journal of Nurse-Midwifery 25(4):40-42, July-August 1980.

The obstetrical service of the Naval Regional Medical Center at Camp Lejeune, North Carolina, has developed a first trimester prenatal education program to encourage early prenatal care. Each week the program enrolls 40 to 55 women who have missed one menstrual period and scored positively on a pregnancy test. Within 3 weeks after completion of the program (9th to 12th week of pregnancy), the women receive physical examinations and reviews of their prenatal records and history forms. An evaluation of the program in 1978 led to several revisions, such as moving the program to the morning hours, expanding the laboratory staff to reduce the time needed to obtain results, showing videocassettes during the waiting period, showing slides during the history-taking interview and the lecture, and incorporating a question-and-answer session into the program. Evaluation of the program indicated that it contributed to more adequate completion of client history forms, greater cooperation among clients, and improved attentiveness due to the use of visual aids.

81-0153
Involving the Southern Rural Church and Students of the Health Professions in Health Education.
Hatch, J. W. and Lovelace, K. A.
Public Health Reports 95(1):23-25, January-February 1980.

The Community Health Education and Resources Utilization Program in Chapel Hill, North Carolina, enables students of public health, medicine, and nursing to develop skills in providing health care to underserved, rural communities with populations of 1,000 to 2,000. Initiated by the School of Public Health at the University of North Carolina, the demonstration project plans to increase the number of people in selected communities who can provide information and counseling about the risks associated with hypertension, pregnancy, diabetes, and other health conditions that community residents identify as problems. The population targeted for this program consists of blacks of low to modest income who have experienced the stress of a rapidly changing social and economic environment. Since the churches provide strong support in these communities, they were selected as the most effective means for intervention; program staff make presentations at the invitation of the congregation. Students in the program select community participants, design program curriculum, coordinate weekly training sessions, select presentations, and perform followup and program evaluations. As a result of this program, students of the health professions receive educational benefits while providing better health to the underserved.

81-0154
Teaching Parents With High-Risk Infants in the Home.
Isaacs, P. C.
Patient Counselling and Health Education 2(2):84-86, 1980.

Forty Salt Lake City, Utah, families evaluated the effectiveness of the newborn-intensive-care coordinator's teaching in helping them adjust to caring for their high-risk infants after discharge from an intensive care center for newborns. Families perceived the service rendered by the coordinator as extremely beneficial because it (1) reduced the anxiety of caretaking and enhanced their ability to care for the infant; and (2) reduced the number of phone calls to the intensive care center and to their physicians concerning the infant's physical behavior and appearance. The families described the coordinator as an effective teacher who was available, gave emotional support, and made them feel competent as parents. Also, the families recommended that the intensive care coordinator work with other families having similar problems. 9 references.

81-0155

Pilot Project for a Statewide Consumer Drug Information Service (Letter).

Lee, B.; Gumpert, N. F.; and Oksas, R. M.

American Journal of Hospital Pharmacy 37(9):1176, September 1980.

Saint Francis Medical Center in Lynwood, California, has initiated a pilot program for testing a telephone service that provides consumers with drug information. Program goals include (1) guiding consumers in proper drug usage so that they can obtain optimal benefits with minimal risks, and (2) educating consumers about drugs to minimize their inhibitions about consulting a physician or pharmacist. The service operates 40 hours per week and is available toll-free to all California residents. The staff consists of pharmacists trained to prepare responses, thus minimizing liability while ensuring that factual information is provided in the proper context. Communication skills and the use of lay language are emphasized during the training period. Calls are documented on logsheets which are maintained for analytical, educational, and liability purposes. Unlike other centers, the service subscribes to consumer magazines and newspapers to keep ahead of media-generated consumer questions. Over 3,600 calls have been received since the program began in February 1979.

81-0156

Innovation in Health Education--Heartline to Health.

Newman, I. M.; Martin, G. L.; Farrell, K. A.; Forker, A. D.; and Eliot, R. S.

Nebraska Medical Journal 62(9):330-332, September 1977.

"Heartline to Health" was developed by the Cardiovascular Center at the University of Nebraska Medical Center to provide the public with basic information on the prevention, detection, and management of cardiovascular disease. The program consisted of 24 weekly 30-minute programs, including a 15-minute discussion between 2 physicians, and a 15-minute period of live telephone questions to the physicians from the television audience. An estimated 20,000 Nebraskans watched "Heartline to Health" during its run. A telephone survey identified the viewing audience as having a median age of 55 and having had more experience with heart disease than nonwatchers. Since the program was designed to educate the public about heart disease, ways of reaching the younger population must be explored. This task is difficult because educational television attracts few young people in the evening. In spite of this problem, the program was considered a success in dealing with a major health problem through community education.

81-0157

Nutritional Rehabilitation at the Hut Level: Educational Impact.

Shingwekar, A. G.; Gopaldas, T.; Srinivasan, N.; Bhargava, V.; and Seth, R.

Journal of Tropical Pediatric and Environmental Child Health (London) 23(2):97-102, April 1977.

Project Poshak, a large-scale study conducted in Madhya Pradesh, India, provided health and nutrition services to young children and pregnant women through the rural government's existing health framework. One component of the project involved nutritional rehabilitation of one malnourished infant in each of five villages to demonstrate the efficacy of the program to the villagers. Three of the mother-infant pairs received food supplements, child care education, and medical services; one pair received the food supplement and educational components; and one pair received only the educational component. Evaluation of the pairs consisted of measuring changes in the children's body weights, clinical assessments, and caloric intake, and measuring the mothers' participation and confidence in the program. The communities' awareness of the program and the attitudinal changes among local program staff indicate that nutritional rehabilitation of severely malnourished infants at the hut level is practical. In each case, the approach proved successful in (1) completely rehabilitating the child without recourse to hospital care, (2) assuring the mother that she could care for her child, (3) creating a high level of awareness of the program among villagers, and (4) convincing the staff of the efficacy of a community education program. 15 references.

81-0158
Integrating Nutritional and Family Planning Education With Food Services in Korean Day Care Centers--An Evaluation.
Sung, K. T.
Public Health Reports 93(2):177-185, March-April 1978.

An integrated day care program serving low-income families in Korea combines the feeding of preschool children with nutrition and family planning education for their mothers. The program is designed to limit family size by improving the nutrition of the children: if parents feel confident that their children will survive, they will feel less need for additional children. Participating day care centers scored higher than nonparticipating centers in the areas of food services, nutrition education, and family planning education and practice. Participating centers also scored substantially higher on items that concerned program planners, including (1) children's weight; (2) mothers' assessment of their children's general physical condition; (3) the age of children when their mothers began to work and to use baby food supplemented with milk; and (4) the proportion of mothers practicing family planning. Through the integrated program, day care centers in Korea provide a broader range of services than the conventional day care centers. 7 references.

81P-0159
Community Education System for High Blood Pressure Control.
Shpegel, R. E.
Northeast Valley Health Corporation, 12756 Van Nuys Boulevard, Pacoima, CA 91331
Funding Source: California State Dept. of Health Services, Sacramento.
August 1973 - Continuing.

The Community Education System for High Blood Pressure Control attempts to (1) ensure that screening services are available to 70 percent of the people living in target cities in the northeast San Fernando Valley; (2) increase by 3 percent the number of persons aware of their hypertension; and (3) increase by 2 percent the number of newly diagnosed hypertensives. The program is administered by a private, nonprofit organization funded through the California State Department of Health Services. Services offered include weekly blood pressure clinics that offer screening, personalized counseling, classes, and referral and followup; community education and detection programs; industrial screening and education programs; consultation with school health instructors regarding high blood pressure and its control; recruitment and training of volunteers to act as blood pressure screeners and educators; distribution of a low-sodium, low-calorie cookbook geared toward black and Mexican-American tastes; and distribution of protocols for the treatment of high blood pressure. The target audience comprises 65,526 persons 20-55 years old. Educational programs for nurses and physicians servicing the target population are evaluated formally. During 1978-79, the program screened 44,872 persons, detected 9,927 persons with high blood pressure, and diagnosed 538 hypertensives; 266 hypertensives entered treatment. These figures indicate that the staffs met stated objectives; stated objectives were again met in the 1979-80 funding period.

81P-0160
Comprehensive Health Improvement Project (CHIP).
Schulkind, M. L.
University of Florida, College of Medicine, Department of Community Health and Family Medicine, Division of Rural Health, Box J1222, J.H.M.H.C., Gainesville, FL 32610
Funding Source: Florida State Dept. of Health and Rehabilitative Services, Tallahassee. Health Program Office.
January 1, 1980 - December 31, 1980.

The Comprehensive Health Improvement Program (CHIP) is designed to bring preventive care to rural residents in underserved areas. Services offered include risk factor screening, screening for early symptoms of chronic diseases, intervention programs to halt the progress of chronic diseases or reduce risk factors, and community-wide education programs designed to encourage rural citizens to adopt and maintain healthful practices and lifestyles. Methods employed include patient education classes in health department clinics, health education classes in area high schools, community education classes, publication of a newsletter, and volunteer services through agencies such as the American Red Cross and the American Heart Association. The target audience consists of the 15,000 residents of Lafayette, Dixie, and Gilchrist Counties in north-central Florida. The program is directed by a physician and is staffed by a registered nurse, a health educator, and a consulting home economics extension agent. The program works with primary care clinics, county health departments, county extension offices, schools, volunteer agencies, and union lumber mills in the area. Service efficacy is evaluated via followup letters after screening programs and through tests and questionnaires dealing with preventive health practices. Preliminary results of program evaluation efforts have shown that rural residents are concerned about health promotion and disease prevention, since the program staff has been asked by various county agencies to coordinate educational programs.

81P-0161
Consumer's Drug Information Service.
Gumpert, N. F. and Oksas, R. M.
St. Francis Medical Center, 3630 E. Imperial Highway, Lynwood, CA 90262
February 1979 - Continuing.

The Consumer's Drug Information Service guides consumers in the proper use of medications and educates them about medications to minimize their inhibitions concerning direct contact with a physician or pharmacist. The information service is provided via a toll-free telephone line available for use 40 hours per week. Extensive call procedures have been developed, and inservice training has been critical to the operation of the program. The service is equipped with current drug information sources as well as with Drugdex and Poisindex, the microfiche drug and poison information systems. The service is available to all California residents. The program is headed by the director of pharmacy services of St. Francis Hospital and staffed by professional pharmacists. Supported by the Los Angeles County Medical Association, the program was funded by a $60,000 grant obtained through the Southern California Association of Philanthropy. As with most drug information services, each call is documented on log sheets, which are maintained for analytical, educational, and liability purposes.

81P-0162
Holy Family Hospital Health Education Program.
Donohue, M.
Holy Family Hospital, 100 N. River Road, Des Plaines, IL 60016
Continuing.

The Holy Family Hospital Health Education Program is designed to supplement traditional medical care with educational efforts, helping community members maintain or improve their health status. Services include a telephone call-in line for health information, a meal delivery service for persons unable to prepare their own meals, a hypertension screening service, breast self-examination classes, a speakers bureau, a coronary club, a diabetes workshop, a club for persons with lung disorders, cardiopulmonary resuscitation classes, a Hemoccult screening program for gastrointestinal problems, prenatal classes, a pediatric orientation program, a smoking cessation clinic, an obstetrical program for pregnant mothers unable to pay for care, a babysitting course, poison control classes, and other information programs.

81P-0163
Lankenau Hospital Health Education Program.
Quigley, B. W.
Lankenau Hospital, Lancaster Ave., west of City Line, Philadelphia, PA 19151
1953 - Continuing.

The Lankenau Hospital Health Education Program is designed to educate patients, the community, and health professionals about health principles and practices. In the area of community health education, the hospital offers Hemoccult examinations, which check for gastrointestinal problems, and blood pressure screening. Courses are offered in weight control, smoking cessation, stress control, cardiac health maintenance, hypertension control, diabetes control, cardiopulmonary resuscitation (CPR), childbirth, cesarean birth, breast-feeding, diabetic control for children, and babysitting. Employee programs include courses in weight control and nutrition, creative fitness, CPR, and assertiveness. Outpatient clinic programs include series on prenatal education, pediatrics, and high blood pressure control. School health programs include sex education classes, a smoking education program, and a museum located in the hospital that focuses on topics such as human development, drugs, alcohol, smoking, and the environment. Graduate health education, offered in cooperation with St. Joseph's University and Beaver College, includes courses on the consumer movement, stress management, maternal and child health, patient education, nutrition, drug use, sexuality, health care since 1960, death and dying, family life, gerontology, human development, and nutrition. As an educational service for inpatients, the hospital has installed a closed-circuit television system.

81P-0164
National Sickle Cell Disease Program.
Reid, C.
National Heart, Lung, and Blood Institute, Bethesda, MD 20205
April 1972 - Continuing.

The National Sickle Cell Disease Program provides a coordinated approach to lessening the debilitating effects of sickle cell disease. Program components include (1) sickle cell disease centers, (2) screening and education clinics, (3) mission-oriented research and development programs, (4) research project grants, (5) public and professional education programs, and (6) hemoglobinopathy training programs. The target audience for these efforts includes health providers, employees, insurance companies, health educators, and persons with sickle cell trait or anemia. The focus has been not only on blacks, but also

on Caucasian groups from southern Europe and the Mediterranean who have exhibited disease symptoms. The program has coordinated its services with the National Institutes of Health, the National Institute of Education, the Job Corps, the American Red Cross, the American Medical Association, and a number of other Federal, State, medical, and educational organizations.

81P-0165
Parent-Peer Education in Drug Use and Values.
Weber, D. M.
Illinois State University, Department of Biological Sciences, Normal, IL 61761
Funding Source: Illinois State Board of Higher Education, Springfield; Illinois State Univ., Normal; Teenage Liquor Concern Committee, Normal, Ill.
1978 - 1979.

The Parent-Peer Education in Drug Use and Values Project was developed by Illinois State University in Bloomington, Illinois, to increase awareness and knowledge of teenage alcohol and drug use in Bloomington and Normal, Illinois. A group of 100 parents was trained via 6 educational modules to provide information to friends and neighbors in an outreach program within their residential areas. Module topics included values clarification and decision making, alcohol and drugs, alternatives to drug use for mood modification, parenting skills, communications skills, and group dynamics. The modules can also be used to train police and fire rescue personnel; health, sociology, and psychology teachers; and drug-rehabilitation-center, emergency-room, collegiate-residence-hall, and industrial-health-center personnel. Most parents rated the project's overall effectiveness favorably and felt that interaction with their own teenagers regarding alcohol and drug use had improved.

81P-0166
Project Heartbeat.
Schofer, L. and Bergman, G.
Philadelphia Health Management Corporation, 530 Walnut Street, Philadelphia, PA 19106
Funding Source: United Way of Southeastern Pennsylvania, Philadelphia; American Heart Association, Philadelphia. Southeastern Pennsylvania Chapter.
January 1978 - Continuing.

Project Heartbeat attempts to reduce by 50 percent mortality from cardiac arrest in the Philadelphia area. The public is instructed in cardiopulmonary resuscitation at 18 area hospitals. The target audience consists of the population of Philadelphia, with special emphasis on the Hispanic community, high school students, and families of high-risk patients. Consulting liaisons are maintained with American Heart Association staff from surrounding counties. Evaluation instruments are employed to determine CPR skill retention and to determine the reasons why people recertify or fail to recertify annually.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-0167
The Role and Impact of the Cancer Education Nurse in Industrial Health Programs.
Mettlin, C.; McCoy, V.; Nuchereno, F.; and Murphy, G. P.
Oncology Nursing Forum 7(2):18-22, Spring 1980.

To enhance the working population's knowledge of cancer, the New York State Division of the American Cancer Society has developed an educational program based on the knowledge and communication skills of the industrial nurse. Through company management, the cancer education nurse (CEN) requests an opportunity to meet with employees to discuss the risks of cancer and means of prevention. The presentation covers methods of early detection, including the nature and effectiveness of Pap smear examination, stool testing, and breast self-examination; risks of cigarette smoking; environmental hazards; and diet. After the first visit, the CEN sets up an information resource center in the workplace. During the program's first 18 months, 108 companies were contacted by the CEN, 70 held programs, and others were scheduled. The high level of industry cooperation and employee participation suggests that the program addressed issues of significant public concern. 8 references.

81-0168
Hypertension: A Major Controllable Public Health Problem--Industry Can Help.
Moser, M.
Occupational Health Nursing 25(8):19-26, August 1977.

Rising corporate health insurance costs and the pervasiveness of hypertension in the United States demand that industry become involved in the management of this disease. Data from companies that have implemented hypertension control programs indicate that such efforts are effective in reducing hypertensive employees' weight, salt intake, and cigarette and alcohol consumption. Though

the percentage of treated hypertensives has risen from 16 percent in 1971 to 29 percent in 1974, 42 percent of those who know they have the problem are receiving inadequate therapy or none at all. Statistics also suggest that motivated physicians can be highly effective in ensuring treatment compliance in their patients. A major task is to convince patients, particularly asymptomatic patients, that the benefits of therapy outweigh the risk of side effects. Hypertensive patients should be made to realize that hypertension is a lifelong problem; it can be asymptomatic; it can cause cardiovascular complications if untreated; and treatment is uncomplicated and inexpensive. Data from several screening and treatment programs demonstrate that current treatment modes can lengthen the life of the average hypertensive by several years. By controlling hypertension, American industry would decrease disability and increase productivity and economic stability. 16 references.

81-0169
Corporate Fitness Programs--How Do They Shape Up?
Pyle, R. L.
Personnel Magazine 56(1):58-67, January-February 1979.

The mutual benefits to individuals and organizations should encourage employers to implement corporate fitness programs. An evaluation of 14 of the 25 to 30 genuine corporate fitness programs in the United States indicates that a typical program is initiated by a high-ranking corporate proponent of fitness; formulated to include a director, 3 activity rooms, equipment, and a $500 annual budget per participant; aimed at reducing coronary risk factors and increasing energy and vitality; directed initially toward executives; and expanded eventually to involve all employees. The average program begins with personal prescriptions for endurance, flexibility, and strength, scheduled three times per week, and expands to include programs on stress reduction, weight control, and smoking cessation. Future programs will concentrate on more specific objectives; provide a broader variety of resources to accommodate the various levels of programs and, to be consistent with justified budgeting, will be directed toward total fitness; rely on clearer objectives that can be related to broader corporate goals; include thorough evaluation components; and involve more aggressive promotion efforts.

81P-0170
Copps Wellness Program.
Copps, T. and Stangel, R. A.
Stevens Point Area YMCA, 1000 Division Street, Stevens Point, WI 54481
Funding Source: Copps Corporation, Stevens Point, Wisc.
June 1979 - Continuing.

The Copps Wellness Program offers employees opportunities to engage in fitness, recreation, and health education activities at no charge. Services offered to participants include a series of physical fitness tests, personal counseling based on test results, goals and strategies to address physical fitness and lifestyle risk factors, and use of athletic facilities at the Young Men's Christian Association. Specific programs are offered in stress control, smoking cessation, cancer education, drug and alcohol counseling, blood pressure screening, fitness testing and counseling, nutrition education, and weight control. A newsletter is published by the YMCA in association with the program. The target audience consists of all 130 corporation employees, 80 percent of whom have joined the program. The administering corporation coordinates all activities with the YMCA. Each year the program is evaluated by the employees who take part and by the YMCA and Copps directors. The corporation believes that the program has increased productivity and reduced absenteeism while increasing employee morale and wellness.

81P-0171
Health Hazard Appraisal.
Sheedy, H. S.
Methodist Hospital of Indiana, Health Care Services, Inc., 1604 North Capitol Avenue, Indianapolis, IN 46202
Continuing.

Health Hazard Appraisal (HHA) of Methodist Hospital of Indiana offers HHA's to over 4,000 employees who are members of the hospital's employee health organization. HHA was adopted by hospital management to (1) improve the health of employees, (2) reduce health care costs by educating employees about the advantages of improving their health habits, and (3) reduce absenteeism and turnover from health-related factors. The program processes a personal history questionnaire by computer and then assigns the individual an assessment age, which can be lower or higher than the individual's chronological age. Consequently, lifestyle modifications are suggested that can reduce the assessment age. To accomplish these lifestyle-modification suggestions, the hospital has implemented programs in hypertension control, smoking cessation, diet, stress management, lifestyle effects, and exercise. Future programs will also cover driving safety, breast examinations, and Pap tests. HHA programming assistance is available to other hospitals, industries, clinics, and practitioners throughout the country.

81P-0172
Occupational Health and Safety Media Campaign.
Gunther, H. C. and Feder, T.
Public Media Center, 25 Scotland Street, San Francisco, CA 94133
Funding Source: Dept. of Labor, Washington, D.C. Occupational Safety and Health Administration.
October 1979 - October 1981.

The Occupational Health and Safety Media Campaign provides information on occupational safety and health to minority and unorganized workers. The program is administered by a nonprofit, full-service advertising and public relations group with headquarters in San Francisco. Services include mass media outreach, publication of various materials, and sponsorship of information and training workshops. The campaign includes broadcast of public service announcements on radio and television; use of information and training workshops; and publication of newspaper and magazine ads, leaflets, brochures, and booklets. Over 120,000 minority employees working in the culinary, garment, and printing industries are reached through the program. The center employs 24 full-time staff members and draws on a large pool of freelance illustrators, photographers, and filmmakers. Program efficacy is assessed through questionnaires and through organizational evaluation at the end of the project.

81P-0173
SHAPE (Safeco Health Action Plan for Everyone).
Nicholson, D.
United Healthcare Corporation, 10700 Meridian Avenue North, Seattle, WA 98133
Funding Source: United Healthcare Corp., Seattle, Wash.
May 1978 - Continuing.

SHAPE (Safeco Health Action Plan for Everyone) is a health improvement program for Safeco's national employee network. The program emphasizes change in aspects of individual lifestyle that could have a detrimental effect upon health and longevity. Participants receive a notebook which contains factual, easy-to-read information on weight loss, reduction of dietary fat intake, healthful eating, aerobic exercise, smoking reduction, stress management, and goal-setting strategies for health improvement. Participants are encouraged to complete and return the SHAPE lifestyle questionnaire included in the notebook, which asks for general information about smoking, eating, and exercise habits. Responses are analyzed and confidential health quality profiles are sent to participants. A SHAPE newsletter, published 10 times a year, provides continuing information, encouragement, and support to program members. An informal study of SHAPE participants revealed that 75 percent improved at least one major aspect of their lifestyles following program participation.

81P-0174
Total Fitness Program.
O'Donnell, R. B.
OPS-Blue Shield, P.O. Box 1071, Portland, OR 97207
Continuing.

The Total Fitness Program is designed to provide OPS-Blue Shield employees with an opportunity for sustained aerobic exercise. The program directs participants in formulating a total fitness program that includes exercise and nutrition regimens. Individual programs involve participants in 20- to 60-minute exercise periods 3-5 days per week, during which time the heart rate is maintained at 60-90 percent of maximum capacity. The program is offered to all employees on a voluntary basis.

HEALTH EDUCATION METHODOLOGY

81-0175
Effects of Limited Radio-Television Advertising in Recruiting New Patients at an Urban Health Department Family Planning Clinic.
Allanson, J. F.
Health Values: Achieving High Level Wellness 4(3):130-133, May-June 1980.

A study was conducted in Kansas City, Missouri, to determine the effects of a short-term, low-cost, and strategically planned radio and television campaign to encourage women to attend the Kansas City Health Department's Family Planning Clinic. In three surveys, conducted in July, August, and November 1978, new patients were asked how they had heard about the clinic. Results of the first survey revealed that family and friends were the primary source in 72 percent of the cases, increasing to 92 percent in the final survey. New-patient arrival increased 176 percent when the media campaign was initiated in August. By November, 2 months after the publicity campaign ended, the survey showed a 36 percent decrease in new-patient arrival, and a drop from 20 percent in August to 9 percent in November of respondents who selected "television and radio" as a source of influence. Results suggest that in a 1-year period, publicity campaign success might increase proportionately with the use of more stations and more prime-time announcements. Other community factors that influence clinic patient recruitment are identified. 10 references.

81-0176
Federal and Non-Federal Resources for Nutritional Information and Services--A Selected List.
Bureau of Community Health Services (DHEW, HSA), Rockville, Md.
Rockville, Md., the Bureau, 81 p., 1979.

Resources for program information, consultation, and technical assistance, for use by primary health centers with nutrition programs, are listed and described. Fact-sheets are offered on national school lunch programs; school breakfast programs; summer food-service programs for children; child-care food programs; food service equipment-assistance programs; food stamp programs; special supplemental food programs for women, infants, and children; nutrition education and training programs; national nutrition programs for older Americans; community food and nutrition programs; and volunteer and other private programs for meals and food. Selected nutrition reference listings include citations of primary health care centers and citations for patients, consumers, and providers of health care.

81-0177
Seminar on Evaluation of Health Education and Behaviour Modification Programs, September 15-16, 1978, Royal York Hotel, Toronto. Proceedings.
Canadian Health Education Society, Ottawa (Canada) and Canadian Council on Health Education, Ottawa (Canada).
Ottawa, Canadian Council on Health Education, 166 p., December 1978.

Proceedings are presented from a seminar on the evaluation of health education and behavior modification programs. Topics include (1) the relationship between evaluation and health education theory, policy, and practice; (2) the contributions of health promotion and social change to Canadians' health; (3) the influence of health education on patient compliance; (4) an evaluation of a community-based alcohol education program; (5) the seat belt program--a case study in avoiding the problems of public education programs; (6) alternative evaluation designs and techniques for alcohol and drug education programs; (7) sequential analysis of health education and behavior modification programs; and (8) the development and evaluation of behavior modification programs for lifestyle intervention. Results from a postseminar evaluation are given. Numerous references.

81-0178
Comparison of Media for Dissemination of Information About Cancer in Rural Communities.
Cantor, A. B.; Miller, M. C., III; Murphy, E.; and Larisey, L.
Southern Medical Journal 72(10):1232-1235, October 1979.

A study was conducted in Orangeburg County, South Carolina, to compare the effectiveness of television, radio, and newspaper media in disseminating cancer education materials. Survey questionnaires were developed for each medium to identify respondents by income, sex, race, age, and other demographic variables. Other questions established respondents' access to television and radio broadcasts and newspapers, as well as their viewing and reading habits. Results indicated that in the primarily rural study population, newspapers were the most effective medium. This superiority was most pronounced among those 45 years old and above, the age group at greatest risk. Those living in small towns were more likely to see the message on television than those in urban or rural areas, and blacks were more likely to hear the message on the radio than whites. Results suggest that target-population characteristics should be considered in designing any mass media health education campaign. 14 references.

81-0179
Health Games, Simulations, and Activities.
Corbin, D. E. and Sleet, D. A.
Health Education 11(4):24-26, July-August 1980.

The Center for Health Games and Simulations at San Diego State University in California houses the largest single collection of health games and simulations and is a resource center for these materials. During the past 5 years, the center has collected, cataloged, and evaluated health games for the benefit of consumers. Materials vary in content complexity and price. Examples of games are given. 10 references.

81-0180
Holistic Health Care, High-Level Wellness and the Abolition of Dis-ease (Editorial).
Davies, N. E.
Southern Medical Journal 72(11):1357-1358, November 1979.

The concept of high-level wellness, which promotes "positive" health rather than the mere absence of disease, is increasingly associated with holistic health care. Holistic health centers are being established in major American cities, and high-level wellness programs are being proposed by many health systems agencies. A number of physicians, unaware of holistic health or high-level wellness, know that many people will support alternatives to the health care system because they are dissatisfied with the current system. If interest in positive health continues, the medical profession will have to reduce the gap between the people and the professionals. 1 reference.

81-0181
Selecting Media for Patient Education.
Frantz, R. A.
Topics in Clinical Nursing 2(2):77-85, July 1980.

A process for selecting patient education media is provided for nurse-teachers. The process involves evaluating three major components including (1) learner characteristics, such as learner perception, reading ability, and self-direction level; (2) task characteristics, which are divided into the cognitive, psychomotor, and affective domains (noting that instructional objectives often contain components from more than one domain); and (3) media characteristics, which include a review of content in terms of accuracy, appropriateness, suitability, and readability, and consideration of media presentation characteristics that affect content delivery. Use of this process enables the nurse-teacher to make decisions that help the patient achieve the desired health behavior. 5 references.

81-0182
Involving Doctors in Health Education About Cancer.
Hill, D. J.; Heffernan, M. W.; and Rice, D. I., eds.
Geneva, International Union Against Cancer (UICC Technical Report Series, Vol. 44), 116 p., 1979.

A guide for health education planners who want to use doctors in cancer education programs is presented. The guide resulted from a project undertaken by a multidisciplinary team sponsored by the International Union Against Cancer and is intended for use by member organizations, such as cancer societies. Topics include (1) the rationale for doctor involvement in cancer education, (2) trends that favor doctor involvement, (3) innovation in cancer education programs, (4) educational objectives, (5) program implementation, (6) survey methods for planners, (7) effective communication with patients, (8) preliminary program trials, and (9) liaison with medical organizations. Numerous references.

81-0183
Guidelines for Teachers.
Katz, L. G.
In: The Sexual and Gender Development of Young Children: The Role of the Educator. Oremland, J. D. and Oremland, E. K., eds. Cambridge, Mass., Ballinger, p. 289-292, 1977.

In regard to new or experimental teaching methods, what teachers as parents prefer for their own children is often different from what they as professionals prefer for their students. An understanding of this is helpful to elementary school teachers in dealing with parents. To reconcile professional and parental concerns, (1) children should be discouraged from engaging in behavior that can conflict with parental preferences; (2) values teaching should be reexamined in light of new knowledge, evidence, and experiences; (3) teachers should decide individually and as a staff whether certain controversial matters are worth raising; (4) teachers should explore all resources available to them; (5) parental preferences and views should be treated as valid, regardless of whether the teacher agrees with them; (6) teachers should take stands on issues they think are worthwhile; (7) teachers should never underestimate the power of ideas; (8) teachers should form a code of ethics within their teaching setting; and (9) teachers should help children to experience their lives as meaningful, satisfying, interesting, and worth living. 2 references.

81-0184
The Effectiveness of Various Methods of Plaque Control Instruction on Short-Term Motivation: A Clinical Study.
Kois, J.; Kotch, H.; Cormier, P. P.; and Laster, L.
Journal of Preventive Dentistry 5(2):27-30, March-April 1978.

Two populations totaling 84 patients participated in identical plaque control programs at the University of Pennsylvania to determine how different modes of presentation, personal supervision, and interaction influence a patient's reduction of plaque. One population consisted of student dental assistants, the other of clinic patients. Patients were randomly assigned to different treatment groups based on their initial disease level. All of the patients were then divided into individual, formal, and informal groups and then subdivided into groups receiving live (teacher) or video presentations. In the next three visits, each group viewed a presentation designed to increase dental IQ (DIQ) and learned to remove plaque. Finally plaque scores were determined. Overall, the effect of the live presentation was not superior to video presentation, and individual instruction was not significantly more successful than group instruction. However, the effect of live versus video presentation on individual instruction was significantly different from the live versus video effect for the group. Neither the initial disease level nor the initial plaque scores were predictive of final plaque scores. However, DIQ demonstrated predictive value in assessing final plaque scores on a short-term basis. No differences were found between the student population and the clinic's patient population with respect to successful plaque removal. 44 references.

81-0185
Toward a Solution of Life-Style Health Problems in a Free Society.
Laframboise, H. L.
In: Health Education; Addresses Presented at the IX International Conference on Health Education, Ottawa, Canada, 29 August-3 September, 1976. Washington, D.C. Pan American Health Organization (Scientific Publication No. 360), p. 48-50, 1978.

In an attempt to provide a new framework for understanding health and to initiate preventive and curative health activities, the Canadian Government published a special working document outlining the four major factors affecting health: human biology, environment, lifestyle, and health care organization. Unlike the other elements of this framework, lifestyle deals with the effect of personal behavior on the health of the individual. Although links between lifestyle and health are well known, there are fundamental issues involved in the solution of lifestyle health problems in a society that prizes individual freedom. The first danger is the creation of a new health bureaucracy that imposes its personal views to solve lifestyle-related health problems. The reconciliation of health goals with individual freedom is best served by (1) offering people information and advice that will permit them to make sound judgements, (2) providing a number of opportunities for people to freely choose activities and make decisions that are in their best interest, (3) helping to neutralize advertising that promotes goods dangerous to health, and (4) encouraging people to question and revise their values.

81-0186
The Learning Laboratory. The Door--A Center of Alternatives.
Mai, L. M.; Pedrick, S. F.; and Greene, M. B.
Rockville, Md., National Institute on Drug Abuse (Services Research Monograph Series) (DHHS Publication No. (ADM) 80-928), 49 p., 1980.

The Learning Laboratory, a 3-year research and demonstration project in New York City designed to treat drug-abusing adolescents, was developed in 1974 by the International Center for Integrative Studies and funded by the National Institute on Drug Abuse. The program helps students who lack sufficient education and goals by providing basic skills workshops, English and Spanish language workshops, special projects and field trips, and individual counseling. Clients participate in regularly scheduled evaluations to assess changes in learning skills, attitudes, and behavior. The effectiveness of the program was evaluated by measuring pre- to postprogram changes in educational progress, drug-use patterns, and involvement in purposeful activities. The participants were found to have significantly improved in all of these areas. Since the program began, 160 clients have participated, with 73 percent of this group remaining in the program for 3 months or more and actively participating for an average of 6.5 months.

81-0187
Development of a Traffic Safety and Alcohol Program for Senior Adults.
Malfetti, J. L. and Winter, D. I.
New York, Columbia University, Teachers College, Safety Research and Education Project, 207 p., 1978.

A program to help elderly persons understand their special vulnerability to alcohol-related traffic fatalities is described. The program consists of an 11-minute animated film, a followup discussion, and a take-home pamphlet. The program addresses the effects of alcohol, alcohol as a food, alcohol absorption, alcohol oxidation, alcohol equivalencies, blood alcohol content, alcohol consumption, alcohol abuse, driving and pedestrian skills, and aging and traffic fatalities. Formulation of these components was based on a survey of the target population, preparation of a tentative program, and administration of preliminary tests to measure changes produced by the program. The overview includes guidelines on planning, promoting, administering, and evaluating a program. A copy of the survey, a discussion of the pre- and posttest batteries and field testing, and copies of tests are appended.

81-0188
Alcohol Abuse Training Relevant to Minority Populations. Handbook: Women.
Memphis State Univ., Tenn. Dept of Special Education and Rehabilitation.
Atlanta, Ga., Southern Area Alcohol Education and Training Program, 32 p., 1977.

Guidelines are offered primarily for use by persons employed in alcohol abuse programs who train others (interested citizens or concerned caregivers) to understand the special problems associated with alcohol abuse among women. Topics include (1) a discussion of the nature and extent of alcohol abuse among women and the patterns of drinking behavior observable among female alcoholics; (2) a model program for training persons who will be working with female alcoholics; (3) an outline of an alcohol education program for alcohol abuse educators, including an alcohol awareness test to measure the educators' training needs; and (4) an annotated bibliography of printed materials and a list of available films and audiovisual aids.

PATIENT EDUCATION

81-0189
Cookbook for a Smokeless Diet.
National Interagency Council on Smoking and Health, New York, N.Y.
New York, the Council, 43 p., 1978.

Adolescent smoking programs are detailed in a cookbook format for the health education professional or for others interested in currently available programs. Topics covered by these programs include affective education, role playing and dramatizations, cardiovascular awareness, biofeedback, comprehensive community programs, smoking conferences, nonsmoking contests, values clarification and behavior modification techniques, multiservice centers for adolescents, peer counseling, life-skills training, youth boards, and comprehensive school curricula.

81-0190
Index of Nutrition Education Materials.
Nutrition Foundation, Inc., Washington, D.C. Office of Education and Public Affairs.
Rev. ed. Washington, D.C., the Foundation, 237 p., 1977.

Nutrition education materials for educators, professionals, and the general public are listed. The index lists pamphlets, booklets, teaching methods, and audiovisual aids available from government agencies; professional societies; and health, consumer, and educational organizations and foundations. Also included are a list of regional and State referral offices and descriptions of selected information centers.

81P-0191
Nutrition Education and Training Program (NET).
Rodriguez, H. S.
Department of Agriculture, Food and Nutrition Service, Nutrition and Technical Services Division, Washington, DC 20250
Continuing.

The Nutrition Education and Training Program (NET) encourages good eating habits, teaches children the relationship between food and health, trains food service personnel in nutrition and food service management, instructs educators in nutrition education, and develops appropriate educational materials and curricula. Target audiences include all children participating or eligible to participate in school lunch programs and related child nutrition education programs. Each participating State employs a nutrition education and training coordinator, who assesses the State's nutrition education needs and develops a plan to meet them. Schools and institutions apply for grants to the State agency, which sets priorities for disbursing its Federal funds. Programs are evaluated annually by the State agency.

81-0192
Educating Patients About Arthritis--Key to Treatment.
American Nurse 10(9):5, 10, September 15, 1978.

The Arthritis Clinic in the University of Colorado teaching hospital uses nurse practitioners to educate patients about the nature of arthritis and to help them function as normally as possible. Each nurse is responsible for 30-35 patients, 20-70 years old, suffering in most cases from rheumatoid arthritis (RA). Patients are reassured when told that only 15 percent of RA patients become severely disabled. The clinic distributes information sheets explaining joint injections and exercises, gold and penicillamine therapies, drug actions, and possible side effects. Patients are cautioned that all of their pain may not be attributable to arthritis and should not be ignored. The nurse also must cope with the common assumption that nothing can be done for arthritis, a fallacy that frequently discourages many persons from seeking treatment. A major challenge in managing arthritis involves the many medications that are administered. Affected persons need to know that aspirin is not prescribed for aches and pains but to reduce inflammation, and must therefore be taken even when they feel well. It is also important to involve the family or other supportive persons in the patient's treatment. Nurse practitioners can be especially effective because they can work with one patient on a continuing basis and recognize needs throughout different stages of the illness.

81-0193
NAQ Forum: Patient Teaching-Patient Rights. Patient Teaching: What We Have Done to It and Whether It's Worth It.
Benedikter, H.
Nursing Administration Quarterly 4(2):81-83, Winter 1980.

The role of patient-education teachers has been formalized by criteria and standards that require (1) establishment of objectives, (2) documentation of teaching that has occurred, and (3) evidence that the patient has understood and benefited from the teaching. To incorporate these criteria into the existing program at Long Beach (California) Community Hospital, nursing-care hours were increased and the medical staff agreed to develop a teaching plan and means for documentation. The program has been evaluated through patient satisfaction surveys and periodic nursing audits; staff compliance to nursing criteria has been approximately 85 percent. Several patient education concerns, which should be studied by nursing researchers, are outlined.

81-0194
The Dilemma of Patient Education.
Bille, D. A.
Nursing Administration Quarterly 4(2):87-95, Winter 1980.

Despite the fact that patient education has been the responsibility of nurses for many years, contradictory practices and beliefs exist which present a dilemma for the nurse who wants to teach. Contradictions based on philosophical, legal, professional, psychological, financial, commercial, ethical, and organizational issues are examined. 9 references.

81-0195
Pre-Operative Information and Post-Operative Recovery.
Boore, J.
NATNews 17(1):16-19, 22, January 1980.

A study assessed the impact of preoperative teaching on 80 patients, 18 to 65 years old, who were having surgery for nonmalignant conditions. A frequency-matching procedure was used to separate the patients into 2 comparable groups of 40 patients each. Patients in the experimental groups were given information about preoperative procedures, anesthesia, and typical postoperative experiences, and instructed in measures to relieve pain. The same amount of time spent with experimental-group patients was spent with patients in the control group; topics of interest to the patient were discussed. All patients were examined to assess stress (measured by amount of steroids secreted), objective physical condition, and subjective state. Among the patients in the control group, the large amounts of steroids secreted postoperatively appeared to be due to anxiety; anxiety was considerably modified by the preoperative preparation given to experimental-group participants. The control group also suffered a significantly greater number of wound infections. These findings confirm other studies that suggest postoperative recovery can be enhanced by assigning nurses to particular patients so that preoperative education, demonstration of physical exercises or relaxation techniques, and anxiety resolution can be accomplished in a personalized manner. 13 references.

81-0196
Collaborative Research Promotes Patient Teaching.
Braak, L. and Cate, M.
Nursing Administration Quarterly 4(2):97-100, Winter 1980.

A research project conducted at Emanuel Hospital in Portland, Oregon, was designed to determine whether emphasis on documentation would improve the quality and consistency of patient education. The primary component of the study was a staff development program based on interviews with patients and staff nurses about patient education and documentation. Results showed that patients received information when nurses collected preliminary data, and that the patients considered this information appropriate and could demonstrate their knowledge. Nurses consistently improved patient teaching documentation, and there was staff consensus regarding the use of existing chart forms and methods. The research project provided the nursing staff with an ongoing mechanism to emphasize patient education and generated nursing interest in implementing other patient education programs. 3 references.

81-0197
Negotiating a Patient Teaching Policy in the Community Hospital.
Dison, C. C. and Kinnaird, L. S.
Nursing Administration Quarterly 4(2):75-79, Winter 1980.

To negotiate a mutually acceptable policy for physicians and nurses, the assistant administrator of nursing services and the patient education coordinator at Baptist Hospital in Miami, Florida, jointly developed guidelines on patient education. The objectives were to define (1) nurses' specific teaching responsibilities, (2) areas in which physician permission was necessary to initiate teaching, and (3) patient teaching areas to be conducted by physicians. The first responsibility of nurses was the assessment of the patient's level of knowledge regarding hospitalization and discharge. Other topics for the nursing staff to develop into a teaching plan included hygiene, skin care, positions assumed when lying down, sitz baths, perineal care, general nutrition, and home nursing care for families. Differences between nurses and physicians regarding medication teaching and instruction about home activity were resolved by compromise. An evaluation, conducted 1 year after implementation of the guidelines, revealed that policy purpose and objectives were being met. 1 reference.

81-0198
A Nursing Challenge: Effective Patient Education.
Engstrand, J. L.
ARN Journal 4(5):15-18, September-October 1979.

An assessment of preventable complications occurring in postrehabilitation patients with spinal cord injuries revealed that complications were most prevalent among patients of lower socioeconomic status. Each incident of complication suggested the need for changes in the existing patient education program provided by nurses. Using the rehabilitation expertise and educational background of staff members, an illustrated textbook for patients with spinal cord injuries was written in simple language. In addition, patient-teaching sessions were strengthened by including new concepts and strategies. Two groups of socioeconomically deprived patients were compared in regard to the incidence of pressure ulcers. One group had received patient education under the old program; the other received the revised program. There were fewer integumentary complications in the revised program group. Results suggest that, by combining the expertise of the health professional and health educator, promising results can be achieved with patients who are most resistant to standard educational methods. 19 references.

81-0199
Health Education From a Group Perspective.
Evans, L. K.
Topics in Clinical Nursing 2(2):45-55, July 1980.

A health-education program-planning model is outlined; it is applicable at all prevention levels and uses the nursing process as a framework. Program stages include (1) selecting a target audience on the basis of need priority, available resources, and likelihood of success; (2) collecting and analyzing demographic and health-related data; (3) utilizing information about the population's state of health, perceptions about its situation, health team members' views about this population, health results sought, and the population's self-care requirements and abilities; (4) establishing program objectives and planning program components, with consideration for measurable objectives, potential barriers, resources required, personnel linkage, funding sources, institutional resources, and patient orientation; (5) establishing a specific implementation plan, including a timetable and chart detailing how the program will be phased in; and (6) deriving an evaluation model that incorporates information about the target population, the amount of service expected, and anticipated program outcomes. 24 references.

81-0200
Preparing Your Patient for Nuclear Medicine: The Safe Diagnostic Tool.
Eymontt, M. J. and Eymontt, D.
Nursing 7(12):46-49, December 1977.

Some basic information is needed to reassure patients being diagnosed by specialists in nuclear medicine. The basic technique involves oral or intravenous administration of a radionuclide. The diagnostician then uses a sensitive detection device to locate or trace the radionuclide in vivo as it moves through the patient's body or becomes concentrated in organs or tissues. Two types of radiation detectors are used in nuclear medicine, including (1) machines designed for the in vitro detection of beta ray and weak gamma ray emissions, such as well counters and liquid scintillation detectors, and (2) machines designed for the in vivo detection of gamma rays, such as organ uptake probes and image-producing devices known as rectilinear scanners and gamma cameras. Physicians may use short descriptions of brain, thyroid gland, lung, and bone imaging as a basis for explanations of specific procedures. Nonimaging tests enable doctors to determine total body water; extracellular water; red-blood-cell mass; plasma volume; and exchangeable sodium, potassium, and other electrolytes. The radiopharmaceutical is injected intravenously, then samples of blood, urine, or both are taken at certain intervals. Most patients are surprised to learn that the radionuclide tests are so physically innocuous and easy to perform.

81-0201
Utilizing Orem's Self-Care Nursing Model in Designing an Educational Program for the Diabetic.
Fitzgerald, S.
Topics in Clinical Nursing 2(2):57-65, July 1980.

Orem's self-care nursing model, in which education is an interactive process between the patient and care provider, forms the framework of a diabetic education program. Components include (1) needs assessment, including (a) professional preparation; (b) assessment of the diabetic's self-care ability; (c) assessment methods and rationale; (d) determination of diagnostic impact; (e) assessment of the diabetic's personal experience with illness; (f) determination of the diabetic's motivation by interacting directly with the diabetic; (g) assessment of the diabetic's controlled use of physical energy and voluntary movement; (h) assessment of learned skills, cerebral cortex functions, attention span, and judgement; (i) assessment of the impact of diabetes on the patient's daily life; (j) assessment of dietary practices and habits; and (k) development of a trusting relationship with the patient; (2) program planning, to ensure that the educational program meets the needs that arise from the disease, the medical regimen, and their effects; (3) implementation, through individualized diabetic instruction and demonstration and return demonstration techniques; and (4) evaluation of the diabetic's ability to manage the disease, through prompting patient recall and providing a role model. 11 references.

81-0202
Counselling in a Hospital-Based Newborn Screening Service.
Headings, V. E.
Patient Counselling and Health Education 2(2):80-83, 1980.

The newborn screening and parent counseling service at Howard University Hospital in Washington, D.C., is an integral part of services for newborn infants. Program components include (1) hospital-based planning and management; (2) integration of screening activities into a unified service; (3) tight integration of screening, education, and counseling; (4) a hospital-based team that provides coherent and indepth counseling for all screening-related needs; (5) a forum for orienting parents to the benefits of preventive health care; and (6) a context in which students learn applied aspects of preventive health care based on early disease detection. The objectives of the program are to promote preventive health care, diagnose and prevent morbidity, and counsel parents regarding reproductive recurrence risk of certain inherited disorders. 18 references.

81-0203
"Retreading" the Experienced Diabetic.
Holt, A.
Diabetes Educator 6(1):14, 22, Spring 1980.

The teaching of experienced diabetics, referred to as "retreading," is undertaken to serve patients who have forgotten earlier instruction or who have not previously received education in hospitals or clinics. The first step in retreading involves investigating the patient's feelings about diabetes, since emotional adjustment problems assume greater importance after technical skills are mastered. Negative emotional responses can interfere with the diabetic's ability or motivation to learn. Identifying these problems at the onset results in more successful teaching. Next, the patient's knowledge and practices should be systematically assessed using an organized format and feedback from the patient and the patient's family to determine learning needs. For patients who are not receptive to teaching, a "back door" approach is recommended, wherein the educator is receptive and listens to the client while providing new, updated information. Individualizing diabetes management is crucial and should include acknowledgement and praise of good management practices. Conversely, problem areas should be identified and criticism should be nonjudgmental.

81-0204
Counselling Patients and Their Families in a Chronic Renal Disease Program.
Korsch, B. M. and Negrete, V. F.
Patient Counselling and Health Education 2(2):87-91, 1980.

Since 1967, an interdisciplinary team at Children's Hospital of Los Angeles, California, has offered comprehensive health care to children with end-stage renal disease and to those undergoing dialysis and kidney transplant. Conferences were found to be useful in providing psychosocial support to patients and in making the treatment team aware of the psychological and physical burdens that treatment places on the family. These conferences provided the basis for developing a protocol for systematic assessment of the resources and weaknesses of children and their families. With conference data, the team can identify patients who will have difficulties adapting to treatment, and those who probably will not comply with posttransplant immunosuppressive therapy (21 patients who subsequently interrupted or stopped immunosuppressive medication were identified at the outset). Appropriate intervention programs to support high risk patients through illness and treatment are currently under development.

81-0205
Improving Patient Education in a Small Community Hospital: A Packet System for Patient Teaching.
Letterman, A. and Gordon, J. J.
Missouri Nurse 49(3):4-5, June-July 1980.

In response to a lack of guidelines or standards for patient education in a small community hospital, a student nurse implemented an informational packet system to assist staff nurses in patient teaching. Responses to a questionnaire indicated that all the nurses felt patient teaching should be included in nursing responsibilities, and 67 percent indicated they had opportunities to teach patients. The questionnaire also revealed that patients were being discharged without adequate information about their condition or about self-care, due to the nurses' lack of organization of teaching materials, lack of emphasis on patient teaching, and lack of an organized system of discharge planning and educational resources. A packet of information was gathered on angina, congestive heart failure, asthma, myocardial infarction, emphysema, hypertension, cerebral-vascular accidents, peptic ulcers, low back pain, and preoperative preparation. Each packet contained information sheets and pamphlets for patients, a flip-chart teaching aid, a documentation and evaluation form, and a guide containing teaching instructions and a protocol for assessing the patient's knowledge. Continual

staff involvement in the project and a program of inservice training ensured cooperation by nurses. The project is an inexpensive, individualized, and easily documented patient teaching system.

81-0206
A Community Hospital's Approach--Decentralized Patient Education.
Malkin, S. and Lauteri, P.
Nursing Administration Quarterly 4(2):101-106, Winter 1980.

The philosophy of the nursing department at Long Beach (California) Community Hospital is that the best teachers for patient and staff education in various clinical areas are the professionals currently practicing in those areas. Thus, prenatal classes are planned and taught by nurses working in labor and delivery. Because assistant head nurses have clinical and managerial expertise, an Assistant Head Nurse Education Group has been formed to develop education program objectives and to promote staff interest and participation in patient education. Potential advantages of decentralized education are that education is integrated into services already being performed, and teaching resources are potentially available at any time. However, effective coordination is necessary, beginning at the nursing administration level, to prevent inconsistent teaching programs. Disadvantages of decentralization include the lack of specialized training, the tendency to overlook post-hospitalization followup and documentation, and the possibility of patient education being sacrificed when schedules are tight. The re-emergence of primary nursing and its emphasis on comprehensive patient care may help to resolve these problems. 3 references.

81-0207
The Patient's Right to Learn or Not to Learn.
McWeeny, M. C.
Nursing Administration Quarterly 4(2):83-87, Winter 1980.

"The Patient's Bill of Rights," published by the American Hospital Association, and the Joint Commission on Accreditation of Hospital's criteria provide a conceptual framework for patient education programs in hospitals. Written patient-teaching goals and planned education as a nursing intervention should become common practice. As consumers of patient education programs, patients are entitled to accurate information, quality education, individualized teaching circumstances, a choice of what they want to know, and a choice between accepting or rejecting patient teaching. Each of these rights is outlined with emphasis on development of teaching skills. 6 references.

81-0208
Protocol for Teaching Hypertensive Patients.
Mitchell, E. S.
American Journal of Nursing 77(5):808-809, May 1977.

A teaching protocol designed for nurses working with patients diagnosed as hypertensive promotes patient understanding of the meaning of blood pressure, the nature of hypertension, and therapy necessary to control hypertension. A program to teach hypertensive patients must (1) help them understand why modifications in behavior need to be continued in the absence of symptoms, (2) dissipate some of the fears and guilt feelings associated with hypertension, (3) correct misunderstandings about the disease, and (4) help patients understand the controllable but incurable nature of hypertension. To make the education process more than just providing information, the nurse must actively involve the patient. Once patient teaching has been completed, a continuing relationship must exist between the patient and health care provider.

81-0209
Patient Teaching in Nursing Practice: A Patient and Family-Centered Approach.
Narrow, B. W.
New York, Wiley, 219 p. 1979.

Guidelines are offered to help nurses (1) acquire a conceptual framework for the process of patient teaching, (2) view patient teaching as an integral part of nursing practice, (3) apply patient teaching, and (4) feel motivated to apply these concepts throughout their careers. Although the guidelines are intended primarily for undergraduate nursing students, many staff nurses will also find them useful. The teaching-learning process is covered in the four component areas of assessment, planning, implementation, and evaluation.

81-0210
Improving Medication Compliance: A Randomized Clinical Trial.
Norell, S. E.
British Medical Journal (London) 2(6197):1031-1033, October 27, 1979.

A medication monitor recording the date and hour a medicine bottle was opened was used to evaluate a program for improving glaucoma patients' treatment compliance at the Huddinge (Sweden) University Hospital. To prevent loss of vision, pilocarpine eye drops were prescribed for 45 men and 37 women 59-90 years old; these patients were randomly divided into 2 groups. Both groups used the medication monitor during two 20-day

periods, but before the second period the experimental group was given (1) a patient education session consisting of a slide show, leaflet instruction, a knowledge test, and a review of material; and (2) a tailoring session to determine when medication could best fit into a patient's daily routine, in order to improve compliance. Experimental-group patients showed significantly improved compliance rates when compared to controls. Missed dosages were reduced by approximately 50 percent, as was the proportion of time that exceeded the prescribed dose interval. Followup studies are recommended to evaluate patient education and tailoring programs for patients on long-term medication. When considering the feasibility of a patient education and tailoring program, physicians should consider the extent to which diagnostic and therapeutic efforts are wasted due to treatment noncompliance. 12 references.

81-0211
Effect of Instruction and Motivation on Dental Knowledge and Behavior Among Wearers of Partial Dentures.
Rantanen, T.; Siirila, H. S.; and Lehvila, P.
Acta Odontologica Scandinavica (Turku) 38(1):9-15, 1980.

Ninety-two patients receiving partial dentures from the Helsinki University Institute of Dentistry were studied to assess the effectiveness of instruction and motivation on the dental knowledge and behavior of the patients. The patients were divided into three groups. The first group was educated and motivated, both as individuals and as a group; the second group was given instruction sheets describing the essential facts related to cleaning and maintaining teeth and dentures, but was offered no individual instruction or motivation; and the third group received no educational intervention. Patient knowledge and behavior was assessed via pre- and postprogram questionnaires and a followup questionnaire sent to the patients 13 months after completion of treatment. By the end of the treatment period, the patients' knowledge was in proportion to the amount of instruction they had received. The groups did not differ significantly in dental health behavior, although there was some indication that increased knowledge and motivation had promoted positive oral hygiene habits. The 13-month followup indicated that the incidence of such habits had declined markedly in all groups, and was no longer related to the amount or type of instruction or motivation received. 10 references.

81-0212
Educational Diagnosis for a Podiatric Program in a High Risk Population.
Roter, H. and Roter, D.
Journal of the American Podiatry Association 70(1):50-53, January 1980.

A health education model for a clinic podiatric population is described. The model combines an emphasis on patient knowledge, attitudes, and beliefs with emphasis on concrete behaviors such as appointment keeping, proper footgear, and prophylaxis. The educational strategy consists of a lecture and small group discussion conducted by a health educator, with participation by a podiatrist, nurse, internist, and pediatrician. Groups of 10 to 15 patients are addressed in weekly sessions during regular clinic hours. The program does not compromise clinic routine, requires minimal administrative bookkeeping, and helps providers better understand their patients. To evaluate the program, patients in a neighboring health facility will be chosen as a control population. 10 references.

81-0213
Helping Young Ostomy Patients Help Themselves.
Tisdale, H.
Canadian Nurse (Ottawa) 73(7):30-32, July 1977.

Sandy, a 5-year-old girl, was admitted to the hospital for surgical construction of an ileal conduit. In an attempt to teach her ostomy care, play therapy was developed. The child was given a doll with a stoma glued on its stomach, several ostomy pouches, micropore tape, a night drainage bag, syringes, surgical sponges, tubing, crayons, and an ostomy coloring book entitled "All About Jimmy." Each item was explained, with the doll acting as a model; the actions were then applied to the patient. On the third morning of therapy, Sandy could tell all about the doll's surgery; by the fourth morning, she had mastered the pouch opening-and-closing device, and she knew the importance of closing the valve after emptying the pouch. After surgery, Sandy's stoma and urinary pouch were checked for leakage, and the procedure was explained while it was being performed. Before Sandy's discharge from the hospital, her parents were taught how to care for the stoma and were given detailed written instructions to take home. During followup visits to the hospital, Sandy and her parents appeared happy and well adjusted to the ileal conduit.

81-0214
Education for Self-Care.
Valiga, T. M.
Topics in Clinical Nursing 2(2):ix-xi, July 1980.

A review of recent books, magazines, and pamphlets reveals a striking increase in self-care-related materials, yet the public is not always assisted in self-care activities. Nurses, utilizing Orem's self-care theory, are in a unique position to help individuals achieve self-care. Self-care is not a physical entity that can be seen in practice situations, but instead involves a way of thinking by nurses that fosters changes in the way they interact with patients. A self-care nursing model should clarify patient goals, a systematic means of meeting these goals, and the nurse's role. Such a nursing model should help patients (1) identify learning needs, (2) focus on present learning aptitude, (3) assume responsibility for learning, and (4) engage in goal-oriented decision making. 5 references.

81-0215
The Effects of Preoperative Teaching on Postoperative Pain.
Voshall, B.
Topics in Clinical Nursing 2(1):39-43, April 1980.

Thirty patients undergoing elective cholecystectomies were studied to assess the effectiveness of preoperative teaching on postoperative pain. A base-line survey of the sample population established previous surgical experiences and measured information about the upcoming operations received from the patients' physicians. Both sample and experimental groups received preoperative education in the anatomy and physiology of the gallbladder; the surgical incision; leg exercises; and exercises for deep breathing, coughing, and turning. Patients in the experimental group received additional information on postoperative pain and means of controlling it. After the operation, all patients were asked to record pain levels over a 2-day period. In addition, the amount of analgesics each patient received for 5 days after the operation and the number of days each patient spent in the hospital were recorded. From the third day after the operation to the discharge of all patients, there was a significant decline in the amount of analgesics requested by experimental-group patients as compared to control-group patients. Also, the average hospital stay for experimental-group patients was shorter than for control-group patients. 8 references.

81-0216
Group Education for the Hypertensive.
Wyka, C. A.; Levesque, P. G.; Ryan, S. L.; and Mattea, E. J.
Cardiovascular Nursing 16(1):1-5, January-February 1980.

A group education program for hypertensive patients at the New Bedford (Massachusetts) Veterans Administration Medical Center was evaluated. The multidisciplinary program consisted of five 90-minute weekly meetings. The hypertension educational level test (HELT) was administered before and after the program, and a patient-behavioral-outcome sheet was utilized to detect any change in health behavior as measured before and 3 months after the program. Scores on the HELT knowledge test improved greatly between the pre- and posttest evaluations. Those patients who scored lowest on preprogram behavioral indices and those who had the greatest number of risk factors showed the greatest positive changes as measured by postprogram behavioral indices. Positive changes included blood pressure reduction, an increase in exercise levels, and weight loss. The marked improvement in HELT scores and behavioral indices suggests the combined benefits of small-group education and a multidisciplinary approach.

81P-0217
Alexian Brothers Medical Center Diabetic Program.
Herlehy, J. and Gattuso, M.
Alexian Brothers Medical Center, 800 West Biesterfield Road, Elk Grove, IL 60067
Continuing.

The Alexian Brothers Medical Center has implemented a program to provide in- and outpatient diabetics and the community with information about diabetes and its control, as well as information on research and support groups in the community. The program includes in- and outpatient classes, offering instruction in the definition of pathophysiology, symptoms of the disease, urine testing, insulin-administration techniques, skin and foot care, acute and chronic complications, medication theory, diet therapy, allowable activities, stress management, and relaxation and recreation. Methods include lectures, films, demonstrations, and group discussions. The program has served 209 inpatients and 37 outpatients and their families. The program is administered by the registered nurse who directs the medical center's nursing education department. Program staff include a registered nurse, a pharmacist, a dietitian, an occupational therapist, a social service worker, and a recreational therapist. Evaluation instruments are being revised.

81P-0218
Brotman Medical Center Patient Education Program.
Harte, H.
Brotman Medical Center, P.O. Box 2459, 3828 Delmas Terrace, Culver City, CA 90230
1979 - Continuing.

The Brotman Medical Center Patient Education Program is designed to reinforce the regimens prescribed by physicians for patients; acquaint patients with hospital procedures and services; present general health information, specific health counseling, and appropriate community referrals; and include the patient's family or significant others in health teaching when appropriate. Upon admission, patients are issued folders containing general health information and an information request slip. The request slip allows patients to ask for specific information, which is then offered through individual counseling by a hospital staff member under the direction of the physician in charge. Educational experiences are documented on a patient-education teaching form by the staff and in the physician's progress notes. In addition, base-line surveys were made of 100 patients, personnel in the nursing education department, and staff physicians. The patient survey indicated that 63 percent of the respondents wanted to know more about hospital procedures; 69 percent wanted to know more about their own particular treatment; 44 percent preferred not to question their doctors; 38 percent have had difficulty adhering to prescribed regimens; 48 percent sometimes forgot doctors' instructions; and 53 percent preferred individual counseling and education sessions. The nursing survey indicated that 57 percent thought patients want to know more about their condition and treatment; 45 percent thought patients' families want to know more about care of the patients; 29 percent never use a structured program for patient teaching; and 34 percent perform routine, informal patient teaching. The physician survey indicated that 87 percent thought that many treatment failures are a result of inadequate patient cooperation.

81P-0219
Life With Diabetes.
Barr, P. A.
University of Michigan, Michigan Diabetes Research and Training Center, Diabetes Center Unit, 3700 Upjohn Center, Ann Arbor, MI 48109
Continuing.

"Life With Diabetes" is a program to provide in- and outpatient diabetics with the knowledge and skills necessary to manage their disease successfully. The program is administered by a federally funded pilot demonstration project that provides comprehensive care to diagnosed diabetics. Weekly classes, taught by a multidisciplinary team of health care professionals, form the center of the program. Ten patient education booklets are used as adjuncts to classroom activities. The target audience includes adults and children with diabetes and their families, and ranges from newly diagnosed patients to people with longstanding cases of diabetes characterized by many complications. The center is coordinated by a physician with the assistance of a registered nurse. The teaching team includes physicians, nurses, dietitians, psychiatrists, and social workers. The education program for each patient is evaluated by means of pre- and postprogram knowledge tests and individual skills assessments.

81P-0220
New England Memorial Hospital Health Education Program.
Stotz, R.
New England Memorial Hospital, Five Woodland Road, Stoneham, MA 02180
Continuing.

The New England Memorial Hospital Health Education Program is designed for patients and surrounding communities. Each year, the hospital offers approximately 60 courses and seminars, with as many as 10 sessions in each, on subjects such as progressive self-improvement, preparation for childbirth, weight control, cardiopulmonary resuscitation, smoking cessation, stress management, coronary risk evaluation, community service, and babysitting. Patient education courses are offered for diabetic, heart, respiratory, and preoperative patients. The courses are also open to the patients' families. Patients with mastectomies and ostomies receive formal instruction on an individual basis. The hospital also offers health screening, information and referral services, and a speakers bureau. Teaching techniques include lectures, seminars, and film presentations. In addition to patients, clients include individuals; businesses; and employee, school, and church groups in the 11-community service area. The health education department is staffed by four health educators (three of whom hold master's degrees in public health), several part-time registered nurses, and a secretary.

81P-0221
St. Patrick Hospital Diabetes Education Program.
Greene, S.
St. Patrick Hospital, Dept. of Educational Services, 500 West Broadway, POB 4587, Missoula, MT 59806
Funding Source: American Diabetes Association, Helena. Montana Affiliate.
Continuing.

The Diabetes Education Program is a 5-day course that covers (1) dealing with complications that can arise as a result of diabetes, (2) understanding and applying drug and diet therapies, (3) adjusting emotionally and attitudinally to the disease, (4) maintaining proper exercise and

activity regimens, and (5) applying proper urine-testing techniques. Methods of instruction consist of lectures and films. The multidisciplinary instruction team includes registered nurses, a dietitian, physicians, a pharmacist, and an occupational therapist.

PROFESSIONAL EDUCATION AND TRAINING

81-0222
Health Profession Field Work Program.
Davidson, M. S.
Health Education 11(4):19-20, July-August 1980.

The Department of Health Professions at Montclair State College in Upper Montclair, New Jersey, offers degrees in health education and allied health, with concentration in either teaching or community health services. All undergraduates concentrating on community health services must complete a professional segment which includes observation of health agencies and a field study in health. A minimum of 90 class hours is required to complete the observation course. Sixty-six of those hours are completed by making observations at selected health institutions, while the remaining 24 hours are devoted to class meetings, preparation of an observation log, and individual conferences with the instructor. For the field-study course, a minimum of 270 hours are required; 231 of those hours are spent in a single field institution and the remainder in class meetings, individual conferences, and log preparation. Most recent graduates obtained jobs in their preferred health area or went to graduate school. Proposed program changes and additions are outlined.

81-0223
Activities of the Department of Foods and Nutrition of the American Medical Association.
Geiger, C. J.
Connecticut Medicine 43(10):655-657, October 1979.

New programs, recent changes in and expansions of older programs, and the activities of the Department of Foods and Nutrition of the American Medical Association are summarized. Topics include medical school nutrition curricula, nutrition scholarships and research fellowships, conferences and publications, guidelines for multivitamin preparation and intravenous nutrition, and public nutrition education. 4 references.

81-0224
Use of Trigger Tapes to Teach Concepts of Nutritional Counseling.
Rossmann, P. P. and Mescher, K. D.
Educational Directions for Dental Auxiliaries 3(4):4-7, September 1978.

To increase nutritional counseling skills of dental hygiene students enrolled in a nutrition course at the University of Iowa, the faculty developed seven audiovisual tapes designed to trigger viewer response. The tapes depict situations in which the nutrition counselor omits one or more principles of nondirective or patient-centered counseling. The principles include establishing rapport with the patient, eliciting the truth from the patient, putting the patient at ease, listening to the patient, allowing the patient to respond without interruption, maintaining eye contact, communicating on the patient's level, investigating the patient's general health and socioeconomic status, and leaving decisions up to the patient. Use of the tapes with groups of 16 or fewer students has proven highly effective in providing a nonthreatening learning experience. The tapes facilitate verbal interaction in student-patient relationships, are easy and inexpensive to produce, require minimal instructor preparation for re-use, and are enjoyed by students. Role playing can serve as an adequate alternative if taping equipment is not available. 4 references.

81-0225
The Value of Short Courses: An Attempt to Evaluate a Four-Day Teaching Programme in Christchurch for Diabetes Educators.
Stafford, J.; Helm, A. M.; and Beaven, D. W.
New Zealand Nursing Journal (Wellington) 72(6):24, June 1979.

In response to increased professional interest in New Zealand's Christchurch programs for diabetes education, a 4-day course was designed for diabetes educators. Thirty-four persons attending the course were given an initial questionnaire to measure knowledge of specialized areas of diabetes that would be covered in lectures or discussion groups during the course. Twenty-four of the educators in attendance were given the identical test at the end of the course; responses from 22 of these were matched (by handwriting and occupation) to the pretest. Results indicated an increase of 18.7 percent in test scores for this group. Overall, the course and its evaluation highlighted problems that can arise in course development and questionnaire design.

81-0226
Learning About Epilepsy.
Svoboda, W. B.
Baltimore, Md., University Park Press, 240 p., 1979.

Guidelines to help epileptic patients and their families manage the disease are presented for use by physicians, nurses, teachers, counselors, and other professionals. Topics include an overview of the disease and typical responses to it, definition of a seizure, types of seizures, causes of seizures, patient examinations, disorders similar to seizure disorders, laboratory diagnosis, acute seizure management, anticonvulsant drug management, side effects of anticonvulsants, other approaches to seizure management, emotional and behavioral consequences of epilepsy, epilepsy and learning problems, restrictions placed on the epileptic patient, resources available to the epileptic, and future trends in the management of epilepsy. A list of resources for further information is appended. Numerous references.

81-0227
Using Medical Specialists in Health Education.
Walston, S. C.
Health Education 11(4):26-27, July-August 1980.

The Department of Health Education at Central Michigan University in Mount Pleasant, Michigan, has initiated a course entitled "Medical Aspects of Health," which reviews recent trends, concepts, philosophies, and methods used in disease treatment and prevention. The faculty member responsible for the course determines course objectives, schedules medical specialists for class presentations, and assists the specialists in planning and class presentation. Students read and critique materials related to each discussion topic, keep notes about class presentations, and participate in question-and-answer sessions. Student evaluations of the course have been positive, particularly in regard to the open class atmosphere and the opportunities to ask questions. More physicians have indicated a desire to participate as speakers than can be included in an 18-week semester.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-0228
Government Attitudes to Health Education: A Crucial Factor in Effective Action.
Hellberg, H.
International Journal of Health Education (Geneva) 23(2):76-81, 1980.

In Finland, all forms of health education are related to government attitudes and action, which take different forms depending upon the circumstances. For example, community action is left to develop on its own, without unnecessary governmental involvement, to encourage community initiative. However, active governmental support is essential to structured social action. The strongest governmental role lies in administrative and legal action in support of health and healthy behavior, ranging from support for training programs and financial grants to the development of frameworks to make community and social action more effective. In the effort to improve the health of their citizens, governments will be looking not to health institutions but will be developing their own national health policies. Coordination and cooperation between government representatives and voluntary health agencies will be needed.

81-0229
The New Politics of Nutrition Education.
Manoff, R. K.
Journal of Nutrition Education 12(2, Suppl. 1):112-115, 1980.

The need for public policy initiatives for nutrition education, particularly in an era of expanded communications technology, was examined in a paper presented at the National Conference on Nutrition Education. Public policy needs include (1) overcoming the limitations of (a) teachers, the classroom, and the general public in regard to receiving and reacting to instruction, and (b) a social environment that can be hostile to sound nutritional practice; (2) forcing an indifferent nutrition establishment to acknowledge that nutritional status depends on modifying the individual and the economic system; and (3) enlarging the social responsibilities of the nutrition educator. Proposals involving the use of new communications media for nutrition education call for a public policy that (1) allocates a fixed share of television and radio time to health and nutrition education, and (2) acknowledges the government's responsibility to promote appropriate foods and dietary goals for Americans. 9 references.

RESEARCH AND EVALUATION

81-0230
Lifestyle Change on the Campus: Pilot Test of a Program to Improve Student Health Practices.
Cormier, A.; Prefontaine, M.; MacDonald, H.; and Stuart, R. B.
In: Behavioral Medicine: Changing Health Lifestyles. Davidson, P. O. and Davidson, S. M., eds. New York, Brunner-Mazel, p. 222-255, 1980.

A program to promote changes in health behavior among 68 college students employed a group discussion and self-monitoring method. Participants completed a questionnaire and underwent pre- and postprogram biomedical measurements to determine the effect of five lifestyle change modules, including relaxation, exercise, self-assertiveness, leisure and sleep, and nutrition. Participants in the lifestyle change sessions were asked to record their success in altering behavior in relation to targets established during weekly discussions. Results indicate (1) no significant change in blood pressure, pulse rate, and serum lipid measurements, suggesting that participants were already within normal limits for those parameters; (2) a significant decrease in the physiological index of stress, suggesting the effectiveness of relaxation procedures; (3) improvement of mood as measured by anger, depression, tension, and fatigue levels; and (4) a high regimen-compliance level, with a majority of participants returning either all or all but one of the lifestyle module self-monitoring sheets. Suggestions for future research are given. 87 references.

81-0231
Sex Education for Adults: Use of a Sexual Knowledge Inventory.
Friedeman, J. S.
Issues in Mental Health Nursing 2(4):43-50, June 1980.

Three studies of elderly women and college students were used to measure the effectiveness of a sexual knowledge questionnaire for evaluating misconceptions about sexuality and as a method of generating discussion on these topics. In the first two studies, one involving 15 black and 15 white elderly women and the other involving 126 college students, both groups revealed great interest in sexual topics, with the students demonstrating more knowledge of sexual topics than did the older subjects. In the third study, 100 elderly women were personally interviewed on sexual knowledge topics, the importance of religion, sex education for adults, and demographic data. Analysis of data from the final study indicated that 51 percent of the women were interested in learning more about sexuality; knowledge of sexual matters was low; and respondents were knowledgeable about sexual issues pertaining to aging and illness, but had a poor understanding of homosexuality, masturbation, and menopause. 3 references.

81-0232
Prenatal Nutrition Classes and Pregnancy Outcome.
Halliday, S. F.
Journal of the Canadian Dietetic Association (Toronto) 39(2):128-134, April 1978.

Seventy-three couples attending prenatal classes at the University Hospital in Saskatoon, Canada, were assessed to measure the effect of prenatal classes on nutritional habits and to investigate the relationship between the nutritional adequacy of the maternal diet and the birth weight of the infant. The couples attended a 2-hour prenatal nutrition class that provided information on the function, source, and quantity of nutrients required during pregnancy, and on maternal weight gain and breast-feeding. The class, moderated by a dietitian, consisted of an informal lecture, a film, and pamphlets. Data on dietary intake during pregnancy were based on a 24-hour dietary recall obtained at the prenatal class. A telephone interview was used to obtain data on dietary intake following pregnancy and information regarding the effect of the prenatal class on the subjects' nutritional behavior. Study findings indicate that (1) a positive correlation exists between the adequacy of the maternal diet and the birth weight of the infant; (2) milk and milk products were the components most often found to be inadequate in the mothers' diets; (3) birth weight increased with maternal weight gain; (4) breast-feeding mothers increased their fluid consumption during feeding; and (5) the nutrition class had a positive effect on both mothers and fathers. 11 references.

81-0233
Nutrition-Education Research: An Interdisciplinary Evaluation and Review.
Levy, S. R.; Iverson, B. K.; and Walberg, H. J.
Health Education Quarterly 7(2):107-126, Summer 1980.

An interdisciplinary evaluation approach was developed to analyze and compare systematically school nutrition education programs. Theoretical models from education, preventive medicine, health education, and statistical evaluation were applied to 22 studies published between 1968 and 1978 to judge program impact on nutrition knowledge, behavior, and attitudes. The studies were compared to determine (1) covariance between pre-

sumed causes and effects, (2) other plausible explanations of covariation, (3) generalizability of the covariation beyond the immediate study, and (4) plausible hypotheses that could be generated about cause and effect constructs. Results of the study indicate that education in classroom, home, and extension settings can affect nutrition behavior. Mass media public-service announcements and the use of school lunchrooms for nutrition education programs seem to be an effective, though neglected, means to increase knowledge and alter behavior. Assessment of the "effect scores" across six widely differing educational approaches indicates that each technique proved effective in positively altering nutrition behavior. These scores also reveal that the more interdisciplinary criteria a study satisfies, the more likely it is to influence knowledge, behavior, and attitudes. 46 references.

81-0234
Toward Wellness: Conversations About Health in Our Society.
National Center for Health Education, San Francisco, Calif. Consultant Panel on the Humanities.
San Francisco, the Center, 65 p., (197-).

Current ideas about health education and the wellness movement are examined by scholars in the fields of anthropology, ethics, theology, futurism, communications, sociology, urbanology, and jurisprudence. Topics include (1) definitions of health, (2) means of integrating lifestyle changes designed to promote health with other changes designed to promote self-actualization, (3) the extent to which acceptance of health is determined by subcultural differences in the population, (4) the consistency between the normative approach and the democratic ethos, and (5) the correct balance between (a) efforts providing information and options to people and (b) efforts exerting influence on behavior through more direct methods.

81-0235
A Study of Selected Preventive Health Services in Metropolitan Detroit.
United Community Services of Metropolitan Detroit, Mich. Preventive Health Task Force.
Detroit, Mich., United Community Services of Metropolitan Detroit, 90 p., 1978.

A 13-member task force studied and surveyed the status of the preventive health services serving the 3-county area of metropolitan Detroit. The investigation focused on prenatal care, well-child care, family planning, primary prevention through immunization, contagious disease prevention, and early detection of chronic diseases. Needs in these areas were assessed from information on death rates, incidence and consequences of various conditions reported in the regional and State health systems plans and in public health and welfare agencies, and results from the Detroit Health Interview Survey. In addition, some 300 responses to an earlier State survey of public and private organizations providing one or more preventive health services were reviewed. As a result of these efforts, the task force developed a questionnaire that was mailed to 105 agencies, institutions, and organizations engaged in preventive health activities. Data from the 78 respondents indicate that preventive services are presently underemphasized, underfunded, underrecognized, and uncoordinated. In addition, the survey found that recordkeeping and procedures for reporting data are not sufficiently standardized. Conclusions and recommendations are discussed.

RISK REDUCTION

81-0236
World Health Day 1980: Smoking or Health, the Choice Is Yours.
WHO Chronicle 34(4):127-130, April 1980.

As part of its 1980 World Health Day antismoking campaign, the World Health Organization has assembled and disseminated expert testimony on (1) the epidemic-like effects of smoking, (2) the particularly destructive effects of smoking on the respiratory system, and (3) legal means of discouraging smokers and the smoking industry. Cigarette consumption in Western nations has been one of the leading causes of morbidity and mortality for over 30 years, and developing nations are apparently being influenced in a similar manner by the promotional campaigns of the cigarette industry. Government action should be taken to discourage public smoking, prohibit tobacco promotion, set upper limits for tar and nicotine content in cigarettes, fund health education that addresses the smoking problem, and promote the development of alternative food crops to replace tobacco. New health education programs should emphasize the dangers of passive smoking and the advantages of healthy lifestyles.

81-0237
The Scientific Basis of Dental Health Education.
Health Education Council, London (England).
British Dental Journal (London) 146(2):51-54, January 16, 1979.

A seminar was organized by the Health Education Council and the British Association for the Study of Community Dentistry to update the scientific basis of dental health education. The participants recommended (1) fluoridation of public water supplies, with fluoride tablets or drops serving as an alternative; (2) restriction of foods and drinks containing sugar to mealtimes, since the number of times sugar enters the mouth determines the rate of dental decay; and (3) daily brushing of the teeth and gums with a fluoride toothpaste and removing dental plaque for the prevention of periodontal disease. Regular toothbrushing alone will have only a small effect on dental decay, but an additional benefit may be gained by using a fluoride dentrifice. Previous recommendations of dental health educators based on little supporting evidence include (1) eating a nutritious diet to increase tooth resistance; (2) eating hard, detersive foods to prevent decay; and (3) brushing the teeth after meals to fight decay. The real causes of dental disease are the frequent ingestion of sugar and the presence of plaque at the gum margins.

81-0238
Vision Health Education: An Idea Whose Time Has Come.
Jones, K. D. and Newcomb, R. D.
Journal of the American Optometric Association 50(10):1089-1092, October 1979.

While vision health education has not received the attention that other areas of health education have, the need for such information and its beneficial effect on community health is evident. As demonstrated in other health areas, vision health education could reduce the number of broken appointments, unpaid bills, and malpractice suits; encourage community support; improve diagnostic success; increase patient compliance; encourage consumer participation; reduce morbidity and mortality; and achieve optimal cost effectiveness. Since the eye is the only place in the body where nerve tissue and blood vessels can be examined without exploratory surgery, patients can be examined for numerous conditions through inexpensive and nonthreatening techniques. Timely optometric intervention with children can prevent (1) perceptual deficits and consequential learning problems, (2) certain refractive errors; (3) amblyopia and strabismus; (4) eye trauma; (5) blindness, reduction of sight, ocular and systemic disease, and loss of health; and (6) loss of comfort. Optometrists should cooperate with health educators to develop techniques of community organization, behavior modification, problem solving, program development, epidemiology, patient education, and research and evaluation. 25 references.

81-0239
Prevention of Periodontal Disease in the Future.
Listgarten, M. A.
Journal of Clinical Periodontology (Copenhagen) 6(7):61-67, December 1979.

Though most forms of periodontal disease can be prevented, preventive goals need to be formulated before successful programs can be implemented. Bacterial control and dietary intervention, particularly fluoridation, can prevent gum disease and caries. To educate the public about these facts and to promote positive public action, basic information on the causes and prevention of periodontal disease should be widely disseminated through the mass media, poster campaigns, school programs, and clinical education programs. Before new knowledge concerning the role of bacteria in periodontal disease can be applied to preventive programs, periodontal flora must be reclassified into a proper taxonomic scheme; better techniques must be developed to isolate and identify suspected pathogens; a system must be developed so that the therapist will not have to analyze the vast number of ecological niches in each patient's mouth each time the periodontal flora are monitored; and additional knowledge must be developed to define the dynamics of the immune response. A program that communicates these developments to the public will vary on a regional basis depending on political, economic, and social circumstances, but successful efforts will be comprehensive, following the client's development from the prenatal stage through old age. 35 references.

81-0240
4-H for LIFE (Lifestyle Improvement for Everyone): Florida Pilot Health Education Program. Final Report to National 4-H Council and the Robert Wood Johnson Foundation.
Moody, L. E.; Colson, K. C.; Milton, R. L.; Williams, C. S.; and Beaulieu, L. J.
Gainesville, Fla., University of Florida, Florida Cooperative Extension Service, Institute of Food and Agricultural Sciences, 123 p., 1980.

The 4-H For LIFE project was instituted to develop a comprehensive health education program for adolescents 12-18 years old. A computerized health profile (health risk assessment) model was tested with 307 teenagers in 4 medically underserved rural counties in Florida. Ten percent of the subjects exhibited one or more abnormal traits during screening periods and were referred to local agencies for additional followup and counseling. As a part of the comprehensive health education program, a series of health education sessions was offered through the schools

and 4-H clubs. These sessions focused on healthy lifestyles, fitness and 4-H exercise trails, stress management, nutrition, interpersonal and community involvement, and survival skills. Program evaluation revealed that the computerized health profile can be used as a tool to stimulate adolescents' interest in personal health risk assessment and to promote their abilities to make positive lifestyle decisions. The profile can only be successful when used as an educational tool, rather than as a simple diagnostic device. 14 references.

81-0241
High Level Wellness and Low Level Wellness: An Overview.
Reif, A. E.
Health Values: Achieving High Level Wellness 2(4):198-210, July-August 1978.

High-level wellness involves (1) continuing improvement in bodily function; (2) continuing progress in one's ability to respond to life's challenges; and (3) increasing oneness of mind, body, and spirit. There are important differences between high-level wellness and the euphoria derived from consumption of tobacco, alcohol, caffeine, or drugs. The criterion for determining the wholesomeness of alcohol, tobacco, drugs, coffee, food, or sports is whether the end result of that particular habit, experience, or substance will increase or decrease the state of wellness. 35 references.

81-0242
Effectiveness of Dental Health Counseling.
Rytomaa, I. and Turtola, L.
Proceedings of the Finnish Dental Society (Helsinki) 75(4):59-62, 1979.

A study involving 160 randomly selected freshman university students in Finland was designed to assess the effectiveness of dental health counseling. Of the 160 students who were invited for dental screening, 136 responded. Using the visible plaque index (VPI) and the gingival bleeding index (GBI), the students' plaque and gingivitis levels were assessed. The presence of aciduric bacteria was also assessed. Of the 136 responding students, 89 were randomly assigned to an experimental group, which received a lecture-counseling session. The lecture detailed factors known to promote dental caries and periodontal diseases and described methods by which these diseases can be controlled. The students in the experimental group were given a toothbrush, toothpaste, toothpicks, dental floss, and three dental health education pamphlets. Three weeks after the initial dental screening process, the VPI and GBI scores had dropped in the experimental group and in the 47-member control group. Upon reexamination 7 months later, the status of both groups had returned to the initial levels. The difference between the scores of the experimental group and the control group was not significant. In the experimental group, aciduric bacteria levels decreased slightly during the study. Although the counseling session was positively accepted by almost all students, it had only a short-term effect. 6 references.

81-0243
Nutrition, Dietitians and the Twenty-First Century.
Silverberg, D. S.
Journal of the Canadian Dietetic Association (Toronto) 38(2):84-86, April 1977.

Data from various sources indicate that nutrition education can improve public attitudes and behavior in regard to high-risk practices. A program in Alberta, Canada, has involved 500 nurses over a 3-year period in an effort to establish blood pressure screening programs throughout the province. Seventy percent of clients contacted by the nurses presented themselves for screening, and 90 percent of those told to report to their own doctors for treatment did so. A followup study conducted 18 months after screening indicated that only 7 percent of the clients had not complied with their prescribed regimens. Programs in the United States, particularly two successful county-level programs in California, support the results of the Alberta program and reinforce the hypothesis that the public is becoming more involved in preventive health care. Future programs in Canada, like successful past programs, should use mass media and telephone campaigns extensively, enlist the cooperation of local physicians, and develop pamphlets to supplement other program components. 7 references.

81-0244
Hypertension Control in North Karelia Before the Intervention of the North Karelia Project.
Tuomilehto, J.; Puska, P.; Virtamo, J.; and Nissinen, A.
Scandinavian Journal of Social Medicine (Stockholm) 8(1):9-15, 1980.

A base-line survey involving a random sample of 4,275 persons, 25 to 59 years old, was carried out in the North Karelia area of Finland, before the implementation of the North Karelia CVD Community Control Project, to measure cardiovascular risk factors in the target population. The study indicated that 21 percent of the women and 15 percent of the men under 45 years old needed treatment

for hypertension. Men generally had higher blood pressure than women, but in all age groups women were more often receiving treatment. Although a majority of the sample population had checked their blood pressure recently, only 50 percent of those aware of their hypertension had received treatment. At the time of the survey examination, only 13 percent of the treated men and 10 percent of the treated women had achieved normotension. Only 20 percent of the men and 33 percent of the women who used drugs to control hypertension had been under treatment for more than 5 years. The need to provide a systematic hypertension control scheme in North Karelia is evident. A systematic method of organizing the long-term followup and treatment services is also needed. 12 references.

81-0245
Teaching Children Self-Care for Chronic Disease Prevention: Obesity Reduction and Smoking Prevention.
Williams, C. L. and Arnold, C. B.
Patient Counselling and Health Education 2(2):92-98, 1980.

"Know Your Body," a general health education program, was developed over 3 years for 1,252 10- to 14-year-old students in 6 New York City area school districts to reduce the prevalence of risk factors associated with cardiovascular disease and cancer in adults. The curriculum included nutrition education, smoking education, and hypertension-control materials. A smaller, experimental, intensive health-behavior program was also developed for obese children. A smoking prevention program was offered to discourage children from starting to smoke. Findings show that (1) such a school-based primary disease prevention program is feasible and highly acceptable; and (2) behavior modification programs concerning weight loss and cigarette smoking had a positive effect on two subset populations within the study schools. However, general health education had little effect in reducing the incidence of extreme clinical values related to physical inactivity, high blood pressure, obesity, or smoking in the total population. Thus, future programs for higher risk children should emphasize behavioral change rather than general education. 19 references.

81P-0246
Boulder Memorial Hospital Health Education Program.
Kendall, K.
Boulder Memorial Hospital, Health Education, 311 Mapleton Avenue, Boulder, CO 80302
Continuing.

Boulder (Colorado) Memorial Hospital offers a health education program designed to reduce health risk factors within the general community. Courses offered include a 5-session smoking cessation clinic (25 participants), a 16-session weight management clinic (20 participants), a 2-session health risk appraisal screening program (2 participants per week), a 15-session stress control clinic (25 participants), a 2-session Red Cross course (12 participants), a 4-session cooking class (25 participants), and single-session health seminars (10 participants). The classes, clinics, and seminars use lectures, films, demonstrations, or group discussions. All programs, except the health seminars, are offered on a fee basis; the health seminars are free.

81P-0247
Campus Alcohol Education Service.
Mills, K. C.
University of North Carolina, Campus Alcohol Education Service, 304 Steele Building 050 A, Chapel Hill, NC 27514
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.; North Carolina Univ., Chapel Hill, Center for Alcohol Studies; North Carolina Univ., Chapel Hill. Div. of Student Affairs.
July 1, 1978 - July 1, 1981.

The Campus Alcohol Education Service is designed to (1) document the extent of student drinking on campus, (2) document the extent of alcohol-related problems among students, (3) minimize alcohol-related problems through peer-designed communication strategies, and (4) develop educational guidelines for future alcohol education programs. The goals will be implemented through a student alcohol survey, a three-credit course on alcohol abuse, residence hall workshops, poster campaigns, community-wide projects, a referral network for students with problems, a demonstration alternative bar for party planning, and training programs for peer educators. All components of the campaign will emphasize peer education. The target audience includes all undergraduate students (16,000) at the University of North Carolina at Chapel Hill, with emphasis on the 8,000 students that are housed in residence halls. Within the university community, the programmers coordinate their activities with resident advisor trainers, campus housing services, student activity groups, the Pan Hel Association, the interfraternity conference, the student union, and residence hall governments. The student alcohol survey allowed planners to identify the differences between drinkers and nondrinkers and to formulate and adjust interventions.

81P-0248
Demonstration Project to Prevent Fetal Alcohol Syndrome and to Intervene in Alcohol Abuse During Pregnancy: The Pregnancy and Health Program.
Little, R. E.
University of Washington, School of Medicine, Coach House 8, GI-30, 2309 NE 48th Street, Seattle, WA 98105
Funding Source: National Inst. on Alcohol Abuse and Alcoholism, (DHHS, ADAMHA), Rockville, Md.
October 1, 1978 - September 30, 1981.

The Pregnancy and Health Program attempts to reduce alcohol consumption by pregnant women in order to lower the number of cases of fetal alcohol syndrome. Program activities include public education, screening and referral services, and inservice training for professionals. The target population consists of all pregnant women in King and Snohomish Counties, Washington, and women in this area who already have alcohol-affected children. Evaluation activities include pre- and postprogram estimates of (1) changes in public and professional awareness, (2) the number of clients who change their drinking habits, and (3) changes in health parameters for children of clients.

81P-0249
Evalu*Life.
Thornton, D.
Health and Welfare Canada, Health Services and Promotion Branch, Health Promotion Directorate, Tobacco, Alcohol, and Risk Assessment Unit, 4th Floor, Jeanne Mance Building, Tunney's Pasture, Ottawa, Ontario K1A 1B6, Canada
1972 - Continuing.

The Evalu*Life program attempts to make people aware of risk factors in their lifestyles and to encourage high-risk persons to adopt lifestyle changes. Services, which include risk factor screening, computer processing of risk factor screening data, counseling to help individuals solve lifestyle problems, and repeated followup screening, are provided free of charge to Canadian health professionals who are willing to ensure that clients receive adequate interpretation of and counseling related to their computer results. The program focuses on computer analysis of health-hazard-appraisal information in relation to such lifestyle factors as physical condition and family history. The program is affiliated with the Society of Prospective Medicine, an international organization of persons involved or interested in intervening in the natural course of disease. The efficacy of the program's health hazard appraisal method has been evaluated in a random controlled trial. The program stimulated reductions in alcohol consumption, motivated increases in physical activity, and stimulated weight reduction, yet did not effect any significant changes in smoking behavior, seatbelt use, or systolic blood pressure.

81P-0250
Feelin' Good.
Kuntzleman, C.; Kuntzleman, B.; and Dodson, D.
Spring Arbor College, Spring Arbor, MI 49283
Funding Source: W. K. Kellogg Foundation, Battle Creek, Mich.
1980 - Continuing.

Feelin' Good focuses on teaching sound health and living habits to elementary and junior high school students and concentrates on exercise, nutrition, weight control, smoking cessation, and stress control as factors that affect cardiac health. Teachers, parents, and the community at large are educated in the use of the multidisciplinary curriculum through booklets, teaching aids, and 2-day workshops. The curriculum involves minicourses held in local recreational centers and schools for grades K-9. The minicourses involve both take-home projects that encourage parental involvement as well as sophisticated Saturday morning gym programs. Over 200,000 children in 100 communities in North America have already been involved in the program in its developmental stages. About 24,000 Jackson County, Michigan, children will be exposed to heart health concepts over the next 3 years. More than 400 teachers, 200 volunteers, and 100 parents will participate by helping the schools provide an environment that supports heart health. The program is directed by a Young Men's Christian Association national program consultant on fitness, and a professor and chairperson of the Department of Physical Education at Jackson (Michigan) Community College. The effort will also employ a coordinator with a master's degree in cardiac rehabilitation and adult fitness, and 24 Spring Arbor (Michigan) College students as teaching aides. The Health Services Research Center of the University of North Carolina at Chapel Hill is contributing to the evaluation of the program.

81P-0251
Fetal Alcohol Syndrome Prevention Project.
Baxter, A.
California Women's Commission on Alcoholism, 239 East Manchester Boulevard, Suite 203, Inglewood, CA 90301
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.
Continuing.

The Fetal Alcohol Syndrome (FAS) Prevention Project is designed to reduce the occurrence of FAS by increasing knowledge about the problem, altering beliefs about the effects of drinking during pregnancy, decreasing women's intentions to drink during pregnancy, and decreasing actual heavy drinking by women at risk. The program is directed toward women and health service personnel in the five health service regions in the Los Angeles area. The public awareness program will involve mass media, community outreach, and medical education components. The media component will include development of a public service announcement (PSA) to be used by 3 major television stations per year, development of 3 PSA's to be used by 20 radio stations per year, 3 television and 12 radio interviews with project personnel per year, publication of 40 articles in each of 20 newspapers, and development of special brochures and materials in Spanish for use in other phases of the project. The community outreach program will include development of a 30-minute presentation for community groups; development of pamphlets for the primary target group; selection and training of 25 volunteers to aid outreach activities; use of 3 industries to support project themes; presentation of 30-minute programs to 144 college, high school, and junior high classes; provision of an information booth for 2 days in 10 shopping centers each year, and participation in community health fairs. The medical education component will involve presentations to 360 physicians, presentation of 108 60-minute programs to other health service personnel, distribution of educational packets to clinics, sponsorship of special booths at meetings and conventions, and development of a speakers bureau of 5 physicians. Project efficacy will be evaluated through onsite process assessments and surveys of women who have just given birth.

81P-0252
Haut Comite d'Etude et d'Information sur l'Alcoolisme (Higher Committee for Research and Information on Alcoholism).
Moyret, H. 27, Rue Oudinot 75700, Paris, France
Continuing.

The Higher Committee for Research and Information on Alcoholism in France has instituted an awareness program on the problems of alcoholism among French adolescents. Services include school-based small-group training sessions; institutional meetings which bring together parents, teachers, and students; and hygiene, health, and press clubs in which students learn to recognize health problems. Material supplied to teachers consists of technical information papers on alcohol-related topics; brochures, leaflets, posters, and films; a publication for use in vocational and technical training; and a multidisciplinary publication, for use by students 15-20 years old, which provides background data on educational activities. Program results are evaluated by appropriate government departments.

81P-0253
Health Hazard Appraisal Program.
Matrigali, B.
University of California, Department of Epidemiology and International Health, 1699 HSW, San Francisco. CA 94143
Continuing.

The Health Hazard Appraisal (HHA) Program performs appraisals for the general public. For a small fee, the program processes a personal history questionnaire by computer, then provides two copies of a computer printout and two pages of explanation. The HHA assigns an appraisal age to the individual, which may be lower or higher than the individual's chronological age. This age assessment is based on the individual's history and behavior. Consequently, lifestyle modifications are suggested that can reduce the assessment age.

81P-0254
Person Education-Developmental Education (PEDE).
Orsello, A. L. 4225 Third Avenue South, Minneapolis, MN 55409
1972 - Continuing.

The Person Education-Developmental Education (PEDE) program involves community members in identifying factors related to alcohol and drug abuse and implementing strategies for attacking these problems. Administered by the Catholic Archdiocese of Minneapolis-St. Paul, the program (1) organizes core groups of parents, students, teachers, and administrators to assess the needs of their communities and to develop and implement responsive action plans; (2) offers inservice training for school social workers, counselors, and nurses; (3) organizes student groups to discuss alcohol and drug problems; (4) provides support groups for those individuals who have completed a treatment program; (5) provides inservice training for teachers and other school faculty; (6) develops school district policies; (7) organizes student and parent peer groups designed to improve members' communication and decision-making skills; (8) provides curriculum analysis and evaluation; and (9) identifies local, State, and national resources to assist in implementing a systems approach to prevention and early intervention. Networking and synergistic concepts are used in all facets of the program. The target population consists of students enrolled in selected schools in Hennepin, Anoka, Ramsey, Scott, and Dakota Counties.

81P-0255
Public Education Program on Drinking and Pregnancy.
Chilcote, S. D., Jr.
Beverage Alcohol Information Council, 425 Thirteenth Street, N. W., Suite 1300, Washington, DC 20004
1979 - Continuing.

The Beverage Alcohol Information Council (BAIC), an organization representing 10 alcohol-industry associations, has responded to a request by the Bureau of Alcohol, Tobacco, and Firearms (BATF) that the industry conduct a public awareness campaign about drinking during pregnancy. The program involves implementing a 3-phase medical education project at Boston University School of Medicine; publishing public-service print messages in 2 monthly magazines with a combined circulation of 1.3 million, circulated to doctors and expectant mothers; distributing posters to 4,000 health clinics throughout the country; distributing 30- and 60-second public service messages to 700 television stations throughout the country; cooperating with the March of Dimes in the 1979-80 campaign in emphasizing fetal alcohol syndrome (FAS); encouraging editors and writers of women's magazines to print articles on FAS; and cooperating with the Education Commission of the States to create a youth education program, centered on an informational booklet. The program focuses its activities on women of childbearing age and the health professionals with whom they come into contact. Organizations independently cooperating with the BAIC program are the Education Commission of the States, American Council on Alcoholism, Raleigh Hills Foundation, American College of Obstetrics and Gynecology, Health Education Foundation, and Women and Health Roundtable. A base-line survey on the level of awareness concerning FAS in America was commissioned and implemented by the BATF, and similar surveys in the future will continue to monitor the level of awareness.

81P-0256
RADAR (Risk Analysis Detection and Reduction) Program.
Kimmel, T. R.
Fulton County Health Department, 99 Butler Street, S. E., Atlanta, GA 30303
1977 - Continuing.

The Risk Analysis Detection and Reduction (RADAR) Program identifies risk factors that affect the health of participants and promotes individual and corporate responsibility for health maintenance. Computer analysis of the health hazard appraisal, one of the chief tools of the program, is combined with other biometric assessments, such as cholesterol measurements. Results of the appraisal and the other biometric measurements are presented in individual or group counseling sessions. The immediate target audience consists of Fulton County, Georgia, health department employees and employees of private companies, with services offered on a cost basis. Data-processing services are also provided for groups able to provide their own biometric measurements and counseling.

SCHOOL HEALTH EDUCATION

81-0257
Assessment of School Health Education in Arizona. Report of a Survey Conducted in Spring 1977.
Arizona State Dept. of Health Services, Phoenix. Office of Health Education.
Phoenix, Ariz., the Department, 51 p., May 1979.

In spring 1977, the Arizona Department of Health Services conducted standardized personal interviews with 5-10 faculty or staff members in each of 69 schools that taught some combination of grades 7-12. Data were collected on participants' formal and informal health education activities, community attitudes toward health education, and perceived needs for technical assistance. Faculty were also questioned about classroom instruction in alcohol and drug use, consumer health and the health care system, environmental health and hazards, family life and sexuality, nutrition, and chronic and communicable disease. Survey results indicate that (1) health education is integrated into the curricula of Arizona schools, but the type and number of courses vary widely; (2) more health education is provided in public high schools than in public junior high schools or private schools; (3) nutrition and environmental health, followed by alcohol and drug education, were the most frequently taught courses, and only 3 courses were labeled sex education; (4) sex education is included in 257 different courses; and (5) consumer health and chronic and communicable diseases were the topics of 2- to 3-week segments of broader courses. A copy of the survey instrument is appended.

81-0258
Project SuperHeart--Year One.
Bellardini, H.; Cashin, G.; Stroble, L.; and Way, J.
Health Education 11(4):11-12, July-August 1980.

The cardiovascular health education component of a school-based heart disease intervention program, de-

signed for 6- to 12-year-old children in New York State schools, was evaluated by using a pre- and posttest control group design. Experimental and control groups received a battery of pre- and posttests to determine physical fitness levels and knowledge of cardiovascular health and disease prevention. Curriculum sections included a cardiovascular system overview, cardiovascular diseases and disease risk factors, prevention of poor health habits, and proper nutritional choices. Two testing instruments were developed: an oral exam for elementary school children on cardiovascular health, and a written test for intermediate students covering cardiovascular system anatomy and physiology, knowledge of heart disease, and disease prevention. Although no significant differences between pre- and posttest results were noted, mean score increases in both test groups indicated that learning took place. Reasons for the lack of difference in test scores are discussed.

81-0259
Health Fair for Kids!
Bennett, P.
Imprint 27(1):22, 70, February 1980.

Health fairs can provide children with a wide range of health information. Student nurses wanting to sponsor a children's health fair should contact the principal of the school to obtain permission and assistance in planning and to determine the particular educational needs of the student population. A 1-day fair for 500 children requires the services of 25 nursing students. Fair exhibits and stalls should be located throughout the school; each one should be assigned to a specific topic. Short talks and visual aids are recommended to maintain the children's interest. Resources in the community available to fair organizers include parent-teacher associations, children's hospitals, and State dental, heart, lung, and dietary associations. Costs of the fair should be kept to a minimum, and an evaluation component should be included in the design.

81-0260
Preventing Children's Dental Disease Through School Programs.
Cowan, E. B., Jr.
Journal of the California Dental Association 7(1):28-35, January 1979.

Basic components of a comprehensive dental health education program for schoolchildren include education, screening and followup, and dental care for needy children. Programs should be comprehensive, ongoing, and well organized by a designated coordinator. With behavior modification as a central goal, such a program often begins with a focus on values clarification. Subsequent subject matter should include instruction on the oral cavity, oral hygiene, diet and nutrition, fluoride, the role of the dentist, and the effects of plaque formation and its relationship to oral disease. Dental screenings undertaken at school sites should not be viewed as substitutes for visits to the dentist, and all participants should be informed about the tentative nature of screening programs. Finally, special funding and financial arrangements with local dentists should be arranged to provide care for indigent children.

81-0261
Actions for Health: Decision-Making and Self-Reliance Activities for Healthful Living, Grades 1-6.
de la Sota, A.; Lewis, M. A.; and Lewis, C. E.
Menlo Park, Calif., Addison-Wesley, 252 p., 1980.

A curriculum designed to instruct elementary school students in decision making, self-reliance, symptom awareness, and balanced living is outlined. The decision-making and self-reliance units teach the basic process of the course and are the foundation of the curriculum. Symptom awareness and balanced living, the two health application units, are designed to be taught after children have mastered the two fundamental units. The symptom awareness unit increases children's awareness of symptoms as cues to action for the 11 most common childhood illnesses and injuries. The balanced living unit rounds out the curriculum by enabling children to balance their nutrition and exercise needs with other areas for a healthy lifestyle. In each of the four units, a series of core lessons has been developed along with certain optional lessons which provide reinforcement.

81-0262
It's Never Too Early for Nutrition Education.
Frankle, R. T.
Journal of School Health 50(7):387-391, September 1980.

Weight Watchers program materials, entitled "The Child's Garden of Eating," were tested in 161 elementary schools in 35 States during April and June 1979. Program objectives were to help each child (1) understand the relationship between food and the body, (2) develop a sense of excitement associated with learning about food, and (3) develop personal responsibility for food selection. Program materials included a read-aloud story, a large classroom poster, an action poem, a board game, food-game playing cards, reproduction masters for copying recipes,

a teacher's guide, and two take-home sheets. The program was evaluated through enrollment reaction cards and an extensive questionnaire distributed to teachers and parents. Both groups reacted positively. 17 references.

81-0263
A Fourth-Grade Adventure in Self-Directed Learning.
Gantz, S. B.
Topics in Clinical Nursing 2(2):29-38, July 1980.

A health education project is examined which (1) actively involved fourth grade students in identifying and meeting health learning needs and (2) used readily available materials to stimulate interest in health and increase knowledge and skills. A relaxed environment was provided in which the nurse-teacher was a parent volunteer, and there were no curriculum requirements, grades, or tests. Topics included nursing activities, bodily functions, dissection and examination of organs, application of a plaster cast, and pulse. The format consisted of introductory questions from the nurse-teacher, student-generated questions, a lecture, review of old skills, practice of self-assessment skills, debate with an active focus on decision making, and student suggestions on the next session topic. Student vocabulary was enhanced by the nurse-teacher's use of anatomical terms. Although there was no formal project evaluation, sixth grade teachers reported 2 years later that these students displayed exceptional interest in health subjects. 17 references.

81-0264
Development of a Junior High School Module in Alcohol Education and Traffic Safety.
Malfetti, J. L.; Simon, K. J.; and Homer, M. M.
New York, Columbia University, Teachers College, Safety Research and Education Project, 269 p., 1977.

A five-lesson program for seventh and eighth grade students about alcohol education and traffic safety is presented. Included are units on alcohol as a drug, alcohol and behavior, decision making in relation to drinking, drinking and driving behavior, and dealing with drinking and driving situations. Each unit delineates objectives, content, techniques, necessary materials, and instructional methods and aids. Discussions of the program rationale, participatory teaching techniques, and evaluation procedures, and a list of references, are appended.

81-0265
Guidelines for Development of School Policies Regarding Smoking.
New York State Education Dept., Albany. Bureau of Drug Education.
Albany, the Department, 48 p., 1980.

Guidelines are presented for designing school smoking policies which are appropriate to local communities and which will effectively treat tobacco education and smoking behavior issues. Topics include considerations in smoking policy development, policy rationale, policy establishment methodology, policy content, implementation stages, and information resources. Information on smoking surveys, policies, laws and regulations, current literature, curriculum development, a peer approach to smoking education, and smoking cessation programs is appended.

81-0266
Political Action and the Value of Health Education--A Case Study of Community Attitudes and Actions in a Legislative Hearing.
Newman, I. M. and Wilson, R. W.
Health Values: Achieving High Level Wellness 4(3):124-129, May-June 1980.

Issues surrounding proposed legislation for comprehensive school-based health education in Nebraska are explored. Themes and arguments of opposing and supporting forces are documented, and the failure of both groups to communicate effectively is detailed. The legislation in question was amended by the Education Committee of the Nebraska Legislature in an attempt to be less offensive to the opposition. However, 6 weeks later the legislative session ended, and the bill was postponed to prevent a vote that would have been politically difficult for many legislators. The case study clearly illustrates the nature of opposition to school health education, the obstacles to gaining legislative support for health education, and the issues that can be expected to arise in public debates. Recommendations for less formal approaches to aiding school health education programs are given.

81-0267
The Health Visitor, Schools and Teaching.
Richardson, J. and Russell, A.
Midwife, Health Visitor and Community Nurse (London) 16(5):198-204, May 1980.

The introduction of a new health education program in Great Britain for 13- to 16-year-old students, called the Schools Council Health Education Projects (SCHEP), has drawn health visitors into the schools to meet the need for more extensive health knowledge than is presently being offered by teacher-training institutions. The health visitor possesses a good knowledge of health education, can relate this knowledge to community problems, is perceived as an expert by students and teachers, and can

ensure continuity between elementary and secondary school programs. To promote an easy transition, schools should establish the credibility of the health visitor as an educator, develop courses specifically for the health visitor, and make the abilities of the health visitor as an advisor and a teacher known to the faculty through conferences and meetings.

81-0268
Getting Corporate Funding for Health Education.
Sparber, P. G.
Journal of School Health 50(7):377-379, September 1980.

An understanding of corporate willingness to fund school health education projects and a checklist for writing effective proposals may help school health educators secure program funding. Corporations often sponsor health education projects for public relations reasons, i.e., to (1) support marketing by contrasting positively with their competitors, (2) avoid or minimize government regulation, (3) attract prospective employees, and (4) maintain the confidence of investors. A good program proposal should include (1) a well-defined statement of the problem to be addressed; (2) a defense of the chosen solution to the problem that contrasts with rejected alternatives and the solutions of other candidates; (3) an outline of a decision-making process responsive to change, as more is learned about problems and solutions; (4) a projection of program self-sufficiency at some scientifically determined time; (5) a clear description of the persons implementing the program, their roles, and a timetable for task completion; and (6) a clear definition of goals and a means of evaluating the achievement of those goals. A program case history is appended.

81-0269
The Chief Scientist Reports...The Dental Health of Edinburgh Nursery School Children.
Sutcliffe, P.
Health Bulletin (Edinburgh) 36(5):271-275, 1978.

Two oral health studies of preschool children were undertaken in Edinburgh, Scotland. The first examined the dental health of 1,453 nursery school children from 49 schools or classes to study the relationship between dental caries, oral cleanliness, and urban deprivation. Results revealed that (1) 53 percent of the 3-year-old children and 37 percent of the 4-year-old children had no history of dental caries; (2) children with poor oral cleanliness had twice as many teeth affected by caries than did children with good oral cleanliness; and (3) both elevated incidence of caries and poor oral cleanliness standards were noted in children from areas of urban deprivation. These findings led to the second study, a 2-month feasibility study of teaching toothbrushing in nursery schools. During the first month, each of 30 children received an average of 45 minutes of professional supervision, which was reduced to 9 minutes per child during the second month. Results revealed a significant improvement in oral cleanliness, and school staff were successful in maintaining the benefits gained. Implications of these results are discussed in terms of school-based dental hygiene programs. 19 references.

81-0270
Teaching CPR to Florida's Students.
Varnes, J. W. and Crone, E. G.
Health Education 11(4):21-22, July-August 1980.

Public school districts and universities in Florida, as a result of support received from a number of sources, are offering instruction in cardiopulmonary resuscitation (CPR). Participating agencies include the American Heart Association (AHA), the Governor's Highway Safety Commission, the American Red Cross, and the school boards of several counties. The AHA supports training of classroom teachers by providing faculty and financial assistance for basic life-support workshops. The highway safety commission awarded the Emergency Services Division of the Department of Health and Rehabilitation Services a grant to purchase CPR equipment to instruct schoolchildren and the general public. Though most school districts use health or physical education classes for CPR training, some have integrated the training into other academic areas. At the university level, students may complete the Red Cross basic life-support course in classes provided by the student government.

81-0271
Developing First Aid Skills.
Wilson, R. K.
Health Education 11(4):27, July-August 1980.

To successfully complete a course in first aid, a student must possess both the knowledge and skills necessary to administer first aid in many situations. Use of "practical situation cards," which describe a variety of detailed emergency situations, enables students to practice skills for reacting to real emergencies.

81-0272
Teaching Teens About Tots.
Witmer, D.
RN Idaho 4(1):5, December 1979.

Child Care is a program offered to high school students in the Boise, Idaho, School District to give them marketable child care skills. Instruction is equally divided between classroom theory and clinical practice in community child care facilities. Content includes prenatal care; influences on maternal and child health; child growth and development, with emphasis on the health-illness continuum and prevention and safety practices; nutrition; first aid; family health behaviors; cultural influences; rights of children; the child with special problems; and child care in community day-care settings. Program evaluation after 13 weeks was very positive. In addition, the program responds to a community need.

81P-0273
"Eat Right to Your Heart's Delight."
Jones, T. W.
Blue Cross of Northeastern Pennsylvania, 70 North Main Street, Wilkes-Barre, PA 18711
January 4, 1979 - March 5, 1979.

To improve the nutrition knowledge and behavior of secondary school students and their families, Pennsylvania Blue Shield and Blue Cross of Northeastern Pennsylvania provided financial support to make the "Eat Right to Your Heart's Delight" program available to high school students in northeastern Pennsylvania. Financial aid is provided to school districts for a film series and accompanying literature for use by secondary schools. The film series, which was developed by the "Mr. Fitness" program under the auspices of the Department of Health, Education, and Welfare, focuses on the importance of good nutrition by steering youngsters away from diets high in calories, saturated fats, and cholesterol. The six-reel series covers modifying recipes to control saturated fats and calories, formulating meatless menus, preparing nutritious meals in no more than 30 minutes, preparing low-fat meat, using chicken in various recipes, and including more seafood in meal plans. Representatives from the schools and from the Commission on Economic Opportunity have informed programmers that the series and accompanying literature have been enthusiastically received.

81P-0274
Alcohol Education Research Project.
Mauss, A. L.
Washington State University, Social Research Center, Pullman, WA 99164
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHEW, ADAMHA), Rockville, Md.
1975 - 1981.

The Social Research Center of Washington State University is engaged in a research project to evaluate the long-term impact of a model alcohol education program upon a target population of youth in grades 4-12. The "Here's Looking at You" alcohol education curriculum has been administered by Educational Service District 121 in King County, Washington, and has undergone development, field testing, and short-term evaluation since 1975. Preliminary evaluation of curriculum components and teacher training workshops indicates that the program has been successful in meeting most objectives. However, program data are being gathered and analyzed on a longitudinal basis through mid-1981, after which a series of articles and reports will be issued. See also 81P-0277.

81P-0275
Comprehensive Health Instruction Program.
Kiefer, H. B.
Fulton Public Schools, 207 East Fifth Street, Fulton, MO 65251
Funding Source: Missouri State Dept. of Elementary and Secondary Education, Jefferson City.
1977 - Continuing.

The Comprehensive Health Instruction Program of Fulton (Missouri) Public Schools was implemented to produce a curriculum guide for use in grades K-12, increase the amount of health instruction available at each grade level, increase students' health knowledge, and improve their health habits. Services include curriculum development and inservice training for the curriculum writing team and for teachers. The curriculum emphasizes "infusion" techniques, integrating health lessons, language arts, social studies, science, and other basic courses. Curriculum guides will eventually be printed for each grade level. The program employs films, filmstrips, posters, games, and library facilities. The multidisciplinary curriculum development team includes a nurse, elementary school counselor, a physical education specialist, and a health education coordinator. The efficacy of the program will be measured by (1) the ability of the team to complete curriculum guides for all grades, (2) a comparison of the results of a health-instruction survey instrument completed by all instructional personnel with data from a base-line survey made in 1976-77, (3) comparison of the pre- versus posttest performances of students, and (4) a comparison of the performance of students on the sixth-grade statewide assessment with 1977 base-line data. The instructional survey indicates that the number of health lessons has increased by a factor of 2.65 compared with the base-line year. Also, third and sixth graders have demonstrated 2 and 6 percent increases, respectively, in health knowledge.

81P-0276
DARTE (Drug Abuse Reduction Through Education).
Kaminsky, K.
Wayne County Intermediate School District, 33500 Van Born Road, Wayne, MI 48184
Funding Source: Michigan State Dept. of Public Health, Lansing. Office of Substance Abuse Services.
1971 - Continuing.

DARTE (Drug Abuse Reduction Through Education) is designed to (1) help adolescents learn how to make decisions, (2) improve adult-student relationships in the school-community setting, (3) promote positive concepts of good physical and emotional health, and (4) provide adolescents and adults with resources to consult in times of stress or trouble. The program staff conducts training workshops for leadership teams of educators, parents, and young people; develops booklets and other curriculum materials to aid the teams in program development; arranges clinics on communication skills, group development, affective education, simulation and games, and other innovative educational approaches to substance abuse education and prevention; and assists in the development and implementation of student-led programs. The target audience includes the faculty, students, parents, and other community members residing in the 36 school districts administered by the Wayne County Intermediate School District. Subjective appraisals by teachers indicate that the program has improved teacher-student relationships.

81P-0277
Here's Looking at You.
Roberts, C.
Educational Service District No. 121, Health Education Department, 1410 South 200th, Seattle, WA 98148
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHEW, ADAMHA), Rockville, MD.
1975 - Continuing.

"Here's Looking at You" is a school-based alcohol education project developed by Educational Service District 121 in Seattle, Washington. The program is designed to help young people make responsible decisions about alcohol. Program contents include (1) a school curriculum for grades K-12; (2) a 4-day inservice teacher-training workshop; and (3) an evaluation system which provides data on teacher-training effectiveness and curriculum impact. The curriculum consists of a teacher's instructional guide and teacher-aid kits. A lesson plan for each day shows how to incorporate program activities into such courses as English, social studies, history, or spelling. Kits include films, charts, instructional games, and puppets. Results from a preliminary evaluation indicate that the curriculum was successful in improving students' knowledge about alcohol and its effects, and that the teacher-training workshops increased teachers' knowledge about alcohol and alcoholism, community treatment resources, and the new curriculum. See also 81P-0274.

81P-0278
Know Your Body (KYB).
Reese, D. R.
Community Health Clinics, Inc., Adolescent Health Program, 1503 3rd Street, North, Nampa, ID 83651
Funding Source: Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
Continuing.

The Know Your Body (KYB) program attempts to reduce the risk of heart disease and cancer by emphasizing positive lifestyles in terms of blood pressure, nutrition, exercise, and smoking. The program is administered by Community Health Clinics of Nampa, Idaho, a private, nonprofit health corporation. The primary component is school health screening, reinforced by poster contests, newsletters, antismoking programs, other student activities, and teaching guides for curriculum enrichment. The "health passport" utilized in the screening is used to record risk factors related to cigarette smoking, high blood pressure, high serum cholesterol, obesity, alcoholism, and inadequate exercise and activity. Health screening results are sent to children, parents, teachers, and school nurses. The target audience consists of 600 junior high school students 11 to 14 years old enrolled in 6 local school districts. The program coordinator holds a master's degree in public health. School nurses are employed to coordinate parent volunteers, who assist in health screening activities. The staff coordinates the program in cooperation with the American Health Foundation and participating school districts. The program contracts for data-processing services, laboratory services, and educational materials. Administration of annual health knowledge tests before and after screening allows assessment of the effectiveness of program activities.

81P-0279
Life Skills Training.
Baird, G.
Suffolk County Department of Health Services, H. Lee Dennison Executive Office Building, Veterans Memorial Highway, Hauppage, NY 11787
1979 - Continuing.

Life Skills Training is a program to reduce smoking and improve decision-making skills among secondary school students. The 12-session classroom curriculum, which can be fit into an average school term, utilizes biofeedback, values clarification, and social skills training to help students resist peer pressure. The curriculum employs biofeedback equipment, audiovisual aids, teachers' manuals, teacher-training workshops, and student guides. The program is aimed at the 300,000 students enrolled in grades 7-12 in the 73 school districts in Suffolk County, New York. Over 600 junior high school students are participating in a pilot program being implemented in 2 schools. Eventually, a similar smoking prevention program as well as a smoking cessation program will be introduced into a senior high school. The smoking prevention program and the School Health Curriculum Project have specific pre- and posttests as well as 3-month followup surveys that will be administered to participating students and control groups. A 5-year study is simultaneously being launched at the local community college to ascertain various trends in health-related behavior, including smoking. Results of the pilot program for junior high school students were favorable. See also 81P-0283.

81P-0280
Nutrition in a Changing World.
The Nutrition Foundation, 888 17th Street, N. W., Washington, DC 20006
Funding Source: Heinz Endowment, Pittsburgh, Pa.
Continuing.

"Nutrition in a Changing World" is an elementary-level curriculum (for grades K-8), developed by educators and nutritionists at Pennsylvania State University and based on extensive classroom testing and teacher evaluation. The program is sponsored by the Nutrition Foundation, a nonprofit organization created by leading companies in food and allied industries. The curriculum covers the need for nutrition; necessary nutrients and necessary quantities of them; ways nutrition needs are met; changing nutritional needs; and ways to study nutrition. The curriculum consists of six units, which are distributed across five age levels and are designed for integration with standard courses. Pre- and posttests, background information, and lists of resource materials are included with each unit.

81P-0281
RAMP (Replication of Alcohol Model for Prevention).
Ethridge, J. S.
Pineland Mental Health and Mental Retardation, P.O. Box 811, Statesboro, GA 30458
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.
1978 - Continuing.

RAMP (Replication of Alcohol Model For Prevention) seeks to help young people make responsible decisions about using alcohol. Program services include 50-hour teacher training workshops, technical assistance in curriculum implementation, and 20-hour training workshops for high school students. Students are trained to make presentations to community groups and school-based clubs, assist teachers with alcohol education units, develop and present skits and plays for elementary school students, develop books and other training materials, lead alcohol education groups for interested peers, assist with curriculum and training development, and provide individual counseling and referral sessions for peers. The target audience includes teachers and students in junior high and high school in Bulloch County, Georgia. A drinking behavior test was administered to all Bulloch County students in grades 6-12 to provide base-line data on current drinking patterns. Teacher workshops, peer-leader training sessions, and curriculum implementation are evaluated through pre- and postprogram testing instruments. In addition to this objective data, subjective feedback is collected by program staff through evaluation forms completed by all involved students and teachers. According to data already collected and analyzed, RAMP has made a positive impact and is an effective model for alcohol education.

81P-0282
Sacramento Preschool Dental Health Program.
Sacramento District Dental Society, 1507 Twenty-First Street, Suite 203, Sacramento, CA 95814
Continuing.

The Sacramento Preschool Dental Health Program provides dental health education to preschool children and their parents. The program was developed by the women's auxiliary of the Sacramento District Dental Society and is being readied for statewide distribution by the California Dental Association's Council on Dental Health. Program components include a parent dental health education meeting and a preschool resource center. The resource center consists of a trunk containing a puppet show, flannel-board stories, role-playing activities, art projects, stories, flip charts, and filmstrips. It is sent fully equipped to preschools and provides at least 2 weeks of dental health projects. In the parents' meeting, which precedes each preschool program, parents are introduced to the resource center, given a presentation on dental health, and issued toothbrushes and disclosing tablets. The program reaches 10,000-15,000 children each year.

81P-0283
School Health Curriculum Project (SHCP).
Myers, M.
Suffolk County Department of Health Services, H. Lee Dennison Executive Office Building, Veterans Memorial Highway, Hauppage, NY 11787
Continuing.

The School Health Curriculum Project (SHCP) seeks to improve the health behaviors and reading levels of elementary school students attending county schools. SHCP comprises basic anatomy, the impact of environment on health, physiology, the etiology of diseases, disease prevention, and the effect of personal choices on health status. Students are encouraged to participate actively, and a "hands on" philosophy is central to curriculum implementation. Inservice training for teachers is provided. Curriculum aids include audiovisual materials, books, tools, and a number of other devices. The curriculum is designed for use by sixth graders, but also can be used for fifth graders. Studies have found that students exposed to the curriculum had significantly improved reading levels as well as health behaviors. See also 81P-0279.

81P-0284
Youth Leadership in Smoking Control Project.
Lung Association of Mid-Maryland, 170 Rollins Avenue, Rockville, MD 20852
Funding Source: National Interagency Council on Smoking and Health, New York, N.Y.
July - November 1977.

The Youth Leadership in Smoking Control Project involved a group of students in planning, implementing, and evaluating smoking education advertising campaigns in their high schools. The program used a weekend workshop to instruct a group of students in effective advertising and peer pressure methods. The campaigns utilized comic adventure serials developed for delivery over school public address systems; campaign buttons; posters; T-shirts; raffles; dramatic presentations; and a "cold turkey day," during which total abstention from smoking was encouraged through peer pressure. The target audiences consisted of the student bodies of John F. Kennedy High School in Silver Spring, Maryland, and Bethesda-Chevy Chase High School in Bethesda, Maryland. The implementation staff included a project coordinator, a workshop planning committee composed of students and faculty volunteers, and a number of additional students to participate in workshop and implementation activities. The program was evaluated through a pretest for workshop-planning-committee and workshop members, a questionnaire allowing planning-committee members to assess recruitment and selection processes, a posttest for planning- and implementation-team members, and a post-program survey of students who were exposed to the program.

SELF-CARE

81-0285
Positive Health: Designs for Action.
Beyrer, M. K.; Cushman, W. P.; Kaplan, R.; and Solleder, M. K.
2nd ed. Philadelphia, Pa., Lea and Febiger. 185 p., 1977.

Guidelines are offered for making decisions regarding self-care and other aspects of health care. Topics include increasing personal effectiveness, appreciating sexuality, using psychoactive drugs, making dietary decisions, reducing the risks of disease and injury, improving environmental health, spending health dollars wisely, and utilizing community health programs. Numerous references.

81-0286
Consumers Learn to Monitor Their Own Health.
McIntyre, M. K.
Topics in Clinical Nursing 2(2):39-44, July 1980.

While a physical examination by a physician tends to identify pathology within the patient, an examination by a nurse tends to identify what is strong and healthy within the patient, as well as what might be considered abnormal. As an attempt to implement nursing assessment on a large scale, a course was developed for the public by the Georgetown University School of Nursing in Washington, D.C. Participants learn what constitutes normal, healthy human form and function, and they examine factors that influence form and function. Each class offers (1) an overview of anatomy, physiology, and health promotion activities; (2) a description and discussion of healthy attributes; (3) a discussion of both common and uncommon available diagnostic technologies; (4) a "hands-on" demonstration of a physical examination; and (5) structured individual self-disclosure about what is healthy or not healthy about the participants' own bodies. Although evaluation results did not demonstrate major shifts in levels of intellectual development, they indicated some upward movement. A 6-month followup is planned for future program participants. 8 references.

81-0287
Health Behaviour and Its Determinants Among Insulin-Dependent Diabetics: Results of the Diabetes Warsaw Study.
Wysocki, M.; Czyzyk, A.; Slonska, Z.; Krolewski, A.; and Jeneczko, D.
Diabete et Metabolisme (Paris) 4(2):117-122, June 1978.

Data were collected in Warsaw, Poland, from 170 insulin-dependent diabetics, 18-41 years old, who had suffered from the disease for periods ranging from 6 months to 12 years. A questionnaire on health behavior measured adherence to diet, insulin injection technique, urine self-testing, and the pattern of action adopted in response to hypo- and hyperglycemia. In addition, knowledge of the disease and other factors was measured. Of the subjects studied, only 40 percent adhered to the diet prescribed, 85 percent maintained regular insulin injections, 79 percent used sugar when hyperglycemic, 50 percent restricted their diet or increased their insulin dose when hyperglycemic, and 18 percent regularly tested their urine for sugar. The level of understanding of the disease, an important determinant of health behavior, was found to be low among 56 percent of the patients. Health education in Poland provides almost every diagnosed diabetic with essential information concerning the disease, insulin, and diet, and this information is presented to each patient by a physician, nurse, or dietitian. The followup stage of education is usually inadequate or not carried out at all, particularly with respect to practical training. 12 references.

81-0288
Helping One Another: A Speculative History of the Self-Help Movement.
Zola, I. K.
Archives of Physical Medicine and Rehabilitation 60(10):452-456, October 1979.

The history of medical self-help groups is traced to illuminate the problems and prospects of the independent-living movement. Topics examined include (1) barriers to self-help, including the often socially unacceptable nature of problems to which such groups have been devoted, the reluctance of people to admit that they need help, and the reluctance of the medical profession to recognize the potential of allied health personnel; (2) the massive rehabilitation of the physically handicapped after World War II, which made certain physical handicaps a national responsibility; (3) the shift from cure to care in the doctor-patient relationship; (4) the rise of psychiatry with its emphasis on the importance of behavior in all aspects of disease; and (5) the current shortage of physicians, which has resulted in the performance of therapeutic tasks by patients. The future of the self-help movement is examined, with emphasis on social, economic, and political obstacles. 10 references.

81P-0289
Brooklyn Breathing Partners.
Iseman, W.
Brooklyn Lung Association, Inc., 293 Schermerhorn St., Brooklyn, NY 11217
December 1976 - Continuing.

Brooklyn (New York) Breathing Partners offers education and group support to enable people with lung diseases to better care for themselves. The program (1) conducts 2-hour classes at four local hospitals on topics related to lung disease, (2) publishes a bimonthly newsletter, (3) offers referral services, (4) operates a telephone hotline, (5) sponsors group discussions, (6) provides films and literature relevant to audience problems, (7) organizes presentations by special speakers, and (8) organizes social activities and a home visiting program. The target audience consists of all adults with lung diseases in Brooklyn; the program presently has 350 members. Program activities are evaluated by using telephone and mail surveys and interviews with structured questionnaires. The program is financed by funds received from the annual Christmas Seal Campaign.

81P-0290
Elder-Ed.
National Institute on Drug Abuse, Office of Communications and Public Affairs, Communications Services Branch, 5600 Fishers Lane, Room 10A-56, Rockville, MD 20857
1979 - Continuing.

Elder-Ed is designed to help elderly persons prevent drug use problems before they occur. The multimedia curriculum covers communicating with doctors about drugs, buying drugs wisely, and taking drugs carefully. Techniques employed include a group leader's guide; a set of participants' booklets; and a three-part film or videotape, each part of which addresses one of the areas covered in the curriculum. The program is directed toward all elderly Americans.

81P-0291
Foundation for Care Research, Education and Planning in Chronic Diseases (CREP Foundation).
Esposito, D. 432 Park Avenue South, New York, NY 10016
August 1979 - Continuing.

The Foundation for Care Research, Education and Planning in Chronic Diseases (CREP) attempts to develop and implement new and more effective systems of treatment, management, and care for patients and families afflicted by multiple sclerosis (MS) or related chronic diseases. The program offers patient education, self-care advice, sex education, and professional education. Other services include publication of a quarterly information magazine for MS patients (circulation near 17,000); referral assistance and liaison services to connect patients and their families with resources designed for their use; operation of a telephone hotline; and assistance in organizing and sponsoring MS conferences, symposia, and workshops. The target group includes 500,000 MS patients, 25,000 physicians who specialize in primary MS care, and all public and private health agencies that deal with MS cases. Funding sources include public and private foundations and individual contributors.

81P-0292
Prescription Parents, Inc.
Lemmo, S. P.O. Box 426, Quincy, MA 02269
March 1973 - Continuing.

Prescription Parents supports parents of children born with a cleft lip or palate, provides advocacy for such children, and educates the public about the problem. Services include organization of meetings of parents and concerned professionals, publication of a newsletter edited by parents, sponsorship of social events for families, provision of legal advocacy to ensure adequate educational services, and public education activities by parents and professionals. The program is offered to all families in Massachusetts who have children afflicted with cleft lip or palate; 550 members currently use program services. The medical advisory board consists of specialists in surgery, otolaryngology, dentistry, speech pathology and audiology, pediatrics, genetics, psychiatry, and psychology. Meetings with staffs of various hospitals ensure mutual communication and the viability of the referral system. The staff also works with health agencies, mental health agencies, and school systems to ensure that specific children receive adequate attention. The efficacy of program activities is assessed twice a year through meetings with professionals from the Boston hospital community.

SEX EDUCATION

81-0293
Sex Education and Contraceptive Practice Amongst Abortion Patients.
Ashton, J. R.
Journal of Biosocial Science 12(2):211-217, April 1980.

An interview study involving 308 women living in Wessex, England, who had just had or were about to have abortions through the National Health Service or in charitable clinics, assessed the relationship between sex education and contraceptive practice among this population. Of the 308 patients interviewed via a semistructured interview schedule, 56 percent were less than 24 years old, 54 percent were single, 33 percent were married, and 13 percent were separated or divorced. Information was obtained as to their sources of sexual knowledge, use of and experience with contraceptives, and intentions with regard to sterilization in the future. While more sex education has apparently been provided in the schools over the last decade, survey results raised doubts about its effectiveness. There appears to be a lack of contraceptive services for younger patients, and family doctors sometimes miss opportunities to offer their patients adequate advice about available methods. 9 references.

81-0294
Evaluating Sex Education Programs.
Burleson, D. L.
In: The Sexual and Gender Development of Young Children: The Role of the Educator. Oremland, J. D. and Oremland, E. K., eds. Cambridge, Mass., Ballinger, p. 257-263, 1977.

The evaluation of sex education programs is difficult due to (1) the lack of clearly defined goals that can be measured precisely, and (2) the fact that program success or failure often depends on the quality of teacher-student and student-students interactions, processes which cannot be replicated. Most research measures changes in knowledge, attitudes or values, or behavior. The most frequently reported programs deal with knowledge acquisition. Information from such programs can be used to (1) establish guidelines on the appropriate age for child to be taught various subjects; (2) investigate children's questions to establish readiness for certain topics; and (3) guide teachers in developing educational material with publishers. Regarding changes in sexual attitudes and values, it would be better to scrutinize the process through which attitudes and values are confronted, challenged, and verified than to devote more effort to the before-and-after

study. Behavioral changes as a result of sex education are difficult to assess. Neither parents nor school administrators favor researchers interviewing children about their sexual behaviors. Three programs--the Family Life Education Program in California; "Christians and the Meaning of Sexuality," developed by the United Methodist Church; and "About Your Sexuality," developed by the Unitarian-Universalist Association--are examined. 7 references.

81-0295
The Family's Influence on Adolescent Sexual Behavior.
Fox, G. L.
Children Today 8(3):21-25, 36, May-June 1979.

An increase in sexual activity among teenagers and a decline in the age at which teenagers become sexually active demand a responsive, programmatic attempt to involve families in the sex education of their children. A review of recent research in this area reveals that (1) the family does not offer adequate direction to the adolescent in the area of sexuality; (2) within the family, mothers are the major source of sexual information for daughters; and (3) the caliber of research on families and sex education is low. Findings from three studies that dealt directly with the mother-daughter relationship indicate that a significant number of mothers do not talk to their daughters about menstruation, conception, contraception, and dating. Among white families, income and educational status appear to correlate positively with mother-child communication about sex, while the opposite seems true among black families. Daughters within families headed by females are more likely to have more than one sexual partner and to use contraceptives. Children who have received sex education from their families are less likely to be sexually experienced, yet more likely to use contraceptives if experienced. Finally, parental role modeling and the general atmosphere of homelife have been empirically correlated with adolescent sexual behavior. More research is needed on the role of the family in teenage sexuality; sex education of boys by the family should be researched; and future educational programs should involve parents. 17 references.

81-0296
Problems in Selection of Materials.
Smithey, W.
In: The Sexual and Gender Development of Young Children: The Role of the Educator. Oremland, J. D. and Oremland, E. K., eds. Cambridge, Mass., Ballinger, p. 249-256, 1977.

Problems surrounding the selection of school sex education materials in the State of California include (1) the selection of materials for schools with different social class compositions; (2) the lack of three-dimensional models, which can be useful in answering children's questions; (3) the tendency of school districts to select materials inoffensive to sex education opponents, usually resulting in selection of materials with little content; and (4) the lack of parental participation in material selection and the need for training sessions to acquaint parents with the program. Public library policies that inhibit the accessibility of sex education materials to children are also discussed. Numerous references.

81P-0297
Family Life Education.
Foote, M. D.
California Department of the Youth Authority, 4241 Williamsbourgh Drive, Sacramento, CA 95823
1971 - Continuing.

The Family Life Education Project provides sexuality education and family life education to youth in correctional institutions. The curriculum guide produced by the project directs the teacher through an educational program for this high-risk population and addresses self-concept, physical development, and sexual behavior. Teaching techniques include group discussion, lectures, guest speakers and panels, films, field trips, question cards, questionnaires, interviews, role playing, photographs, graffiti boards, posters, and a drawing exercise. Appended to the curriculum are an annotated bibliography, lists of community resources, laws relating to sex, answers to frequently asked questions, a menstrual calendar, and a copy of the evaluation questionnaire used in the curriculum. The educational program was developed by the project director and two family life education teachers, with input from parole agents, institutional staff, physicians, and youth wards in correctional institutions. The model was experimentally implemented in two youth authority institutions in conjunction with the Maternal Health and Family Planning Unit of the California Department of Public Health. The program's effectiveness in educating youth is evaluated by means of questionnaires and interviews.

81P-0298
Parent-Child Sex Education Program.
Peterson, L.
Family Guidance Center, Family Planning Department, 200 Corby Building, Saint Joseph, MO 64501
Funding Source: United Way of St. Joseph, Mo.; Dept. of Health and Human Services, Washington, D.C.
1976 - Continuing.

The Parent-Child Sex Education Program offers curricula for 9- to 17-year-old children and their parents in an effort to lower the number of unwanted pregnancies among teenagers. The program uses a manual which includes different course outlines for preadolescent girls and their mothers, adolescent girls and their mothers, preadolescent boys and their fathers, and adolescent boys and their fathers. The manual contains course outlines; minilecture outlines and notes; a list of recommended films and pamphlets; tips for introducing the courses in the community; and activities designed to stimulate discussion, promote parent-child interaction and communication, and encourage exploration of feelings and beliefs. On occasion, the staff has offered training workshops for other family planning staffs, community workers, teachers, and interested health professionals. The sex education curricula are offered through or sponsored by parent-teacher associations, Young Women's Christian Associations, Young Men's Christian Associations, community education groups, youth organizations, and churches. Responses to questionnaires by participants indicate that the program is being accepted and is considered valuable.

81P-0299
Teen Initiative Project.
Beal, P.
Forsyth County Health Department, Division of Health Education, P.O. Box 2975, 741 N. Highland Avenue, Winston-Salem, NC 27102
January 1979 - Continuing.

The Teen Initiative Project is designed to help adolescents make responsible decisions and cope with the conflicts of adolescent sexuality in order to reduce the number of unwanted pregnancies and cases of venereal disease. The community education service, which is the core of the program, consists of group and individual discussion sessions on formulating and maintaining a good self-concept, decision making on important issues, dating and social behavior, communicating with parents, accepting and maintaining sexual abstinence, dealing with venereal disease, and using contraceptives. Sessions are conducted for church and civic groups, community clubs, informal neighborhood groups, and recreation centers. The program is directed toward adolescents 10-19 years old in Forsyth County, North Carolina; counselors have reached 4,810 adolescents since the program began. The staff consists of three health educators. Evaluations after each group session have indicated that the program goals are being met.

81P-0300
YHED (Youth Health Education Department) Teen Services.
Scott, O. M. Teucer House, P.O. Box 1324, Hamilton 5, Bermuda
June 1967 - Continuing.

The Bermuda YHED (Youth Health Education Department) Teen Services attempts to (1) prevent and reduce the number of unwanted pregnancies among sexually active adolescents, (2) ensure the continuance of education for pregnant teenage girls, (3) encourage fathers to be an integral part of a mother-father-baby trio, and (4) enable young people to be better prepared for childbearing. The program is funded by private and government grants, donations, and community efforts. Services include community education; high school extension classes for pregnant teenage girls; sex education for males in correctional institutions; counseling for sexually active adolescents, pregnant teens, and teenage fathers; and a residential group home to provide emergency and temporary housing for young women in need. Methods include high school rap groups, lectures and discussions with parent-teacher associations and other community groups, television commercials and special television programs, an annual teen conference, and lending library facilities. Coordination with concerned professionals and other programs is achieved through a referral network, liaisons with high school principals, and referral liaisons with private doctors and a hospital. The target audience consists of adolescents 12-19 years old, with emphasis on individuals from middle and lower income families. Approximately 90-100 new referrals have been received annually since June 1967. The program has 10 full-time staff members. A 5-year study of girls attending the continuation school has been completed.

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CURRENT AWARENESS IN HEALTH EDUCATION

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COMMUNITY HEALTH EDUCATION

81-0301
Alcohol Education: A Campaign by the Health Education Council.
Nursing Mirror (Sussex), 145(21):7, November 24, 1977.

The British Health Education Council is working with the North East Council on Alcoholism to implement a campaign in which television, radio, press advertisements, and leaflets emphasize the dangers of excessive drinking and the strains it can place on family life and personal relationships. It is estimated that 11 in every 1,000 adults in Great Britain have a serious drinking problem. Statistics reveal increases in death from cirrhosis of the liver, admission of persons with alcohol-related problems to mental hospitals, crimes in which alcohol is a factor, and alcohol misuse among young people and females. To combat these trends, the campaign will (1) encourage prevention through community education; (2) motivate persons with alcohol-related problems to seek help; and (3) promote referrals by physicians, social workers, probation officers, health visitors, nurses, and counselors.

81-0302
Developing a Wellness Model in Family Practice.
Albert, M. P. and Caughron, S. D.
Physician's Patient Education Newsletter 3(5):3-4, October 1980.

The traditional medical approach, focusing on the diagnosis and treatment of pathologies, is not an effective approach to lifestyle-related diseases. The Wellness Center, established in 1979 in Charlottesville, Virginia, focuses on major lifestyle traits such as nutrition, exercise, stress, destructive habits, interpersonal interactions, recreation, rest, and work. Questionnaires and other screening instruments used at the center incorporate wellness themes, including items dealing with belief systems and environmental factors. Counseling clients about the resolution of stress is a central activity of the institution. Approximately 50 percent of the visits made by the center's 500-600 patients are for primary prevention. Blue Shield will reimburse patients for such visits when a legitimate diagnosis is made. 5 references.

81-0303
Optional Immunizations as Parameter of Parents' Behavioral Change in Health Needs of Their Off-Springs.
Azis, A.; Rasjid, A.; Sudijanto; and Kurdi, R.
Paediatrica Indonesiana (Djakarta) 19(11-12):265-275, November-December 1979.

Services provided by a maternal and child health (MCH) clinic of the University of Indonesia Medical School were introduced to the surrounding community via individual and group contacts. A study was conducted to measure parents' behavioral changes regarding MCH clinic service by measuring either the percentage of immunized children or by comparing parents' reasons for visiting the clinic. A stratified, systematic sampling of patient files from the year 1975 was undertaken, and data were collected on immunization against tuberculosis, smallpox, diphtheria, pertussis, tetanus, cholera, typhoid and paratyphoid fever, and poliomyelitis. Results revealed that parents brought their 1- to 5-year-old children to the center for medical treatment more than for immunizations and consultation. Results confirm that optional immunizations help increase parental awareness of children's health needs. 5 references.

81-0304
Community Dentistry.
Boghani, C. P.
Journal of the Indian Dental Association 51(2):43-46, February 1979.

The importance of community dental services--a system consisting of dental surgeons, health educators, hygienists, auxiliaries, and social workers--is outlined. Topics include (1) the private practitioner's role; (2) the procedural pattern of the individual clinician and community health worker; (3) community dentistry tools, consisting of problem identification, planning and evaluation, epidemiology, and social and behavioral services; (4) guidelines for dental health education programs for children and adults; (5) suggestions for increasing the dental health educator's effectiveness; (6) preventive dentistry, including primary, secondary, and tertiary prevention strategies; and (7) the need to meet the demand for dental care. 12 references.

81-0305
How to Save Lives and Money: Prevent Heart Attacks and Strokes by Treatment of High Blood Pressure. Milwaukee's Life Saving Program, Outstanding in the United States.
Citizens for the Treatment of High Blood Pressure, Inc., Washington, D.C.
Washington, D.C., Citizens for the Treatment of High Blood Pressure, 12 p., (1978?).

In April 1978, the Director of the National Heart, Lung, and Blood Institute singled out the Milwaukee (Wisconsin) High Blood Pressure Program as the best such program in the nation in terms of death reduction and cost effectiveness. This description of the program covers (1) results of a high blood pressure survey of approximately 200,000 Milwaukee County residents; (2) means of reaching people with untreated high blood pressure; (3) program-planning-structure design; (4) the screening protocol; (5) educational aspects; (6) annual costs, and percentages contributed by various health and community organizations; (7) selection of public and industrial screening sites; (8) public relations aspects, including mass media use, public education via public relations, patient education, and physician education; and (9) statistical data, including hypertension prevalence rates by age and sex, and comparative trends in mortality reductions. The program demonstrates that extensive public education can be conducted in any community for a small amount of money.

81-0306
Priorities in Planning and Evaluating Community Oral Health Programs.
Frazier, P. J. and Horowitz, A. M.
Family and Community Health 3(3):103-113, November 1980.

The fact that $13.6 billion was spent in the United States on dental treatment in 1979, combined with the fact that many communities do not benefit from well-known oral health programs such as fluoridation, underscores the need for critical problem analysis and planning before implementation of community oral health programs. Persons responsible for planning and implementing such programs should assess the relative effectiveness and practicality of available preventive measures, examine community conditions to determine the feasibility of initiating specific procedures or program components, understand the requirement for multiple program components, and initiate the social decision-making processes necessary to implement programs to improve community oral health. The steps required for planning include collection of relevant information and definition of problem areas, specification of short- and long-term goals and objectives, definition of target populations and identification of resources, identification of barriers to program development, implementation and monitoring of programs, and evaluation of programs. Finally, programmers should ensure that the program has components to promote community water fluoridation, fluoridation of school water in rural areas, school-based self-applied fluoride programs, dental treatment services, diet control, and school-based oral health education programs. 21 references.

81-0307
Supplementary Feeding Programmes: The Case for Programme Information and Nutrition Education Support.
Gopaldas, T.
Food and Nutrition (Rome) 4(1-2):15-19, 1978.

Project Poshak, which was implemented in the largest State in India in 1971-75, involved the concept of a nutrition package, consisting of food supplements, basic health and medical services, and child care education. The project served 12 districts, 514 villages, 13,000 mothers with children, and 2,500 pregnant and lactating women. Communication techniques included personal contact, pamphlets, slide shows, posters, films, role plays, and home visitation of mothers with malnourished children. Components included precooked food to draw rural people into the health services, village-level cooking demonstrations, mass media reinforcing the demonstrations, and a growth chart recording each child's complete medical history. In addition, the project targeted one malnourished child in each of eight villages for special care to demonstrate the efficacy of the program to other villagers. The overall project, which cost $25.50 per child per year, was implemented by a field leader, a team of pediatricians, 88 medical officers, 70 female health visitors, and over 300 midwives. Overall participation by the target population was 43 percent, and results of base-line and final surveys indicated that sound dietary practices and related health concepts were developed among the population. 2 references.

81-0308
A Statewide Decentralized Public Drug Information System.
Montagne, M.; Clute, S. S.; and McKennell, T.
American Journal of Hospital Pharmacy 37(9):1211-1215, September 1980.

A statewide drug information system was developed for use by health professionals and consumers in Minnesota. Twenty-one satellite drug-information centers in community or hospital pharmacies are linked by a WATS line to the library of the University of Minnesota College of Pharmacy in Minneapolis. Consumers' questions are handled through the satellite centers, with pharmacists referring to the central information source as needed. All pharmacists are trained in a 1.5-day program that covers consultation and communication skills, drug information retrieval and distribution, practical applications, promotion of drug-information services, and resources and referrals. The average amount of service time provided by pharmacy sites is 15-20 minutes per day. 14 references.

81-0309
Communicating Health Information in School and Community. Keynote Address Presented at the Third Annual New York City Health Education Conference, November 17, 1979, New York, New York.
Pearson, C. E.
New York, Mt. Sinai Medical Center, 9 p., 1979.

A cooperative health education program for New York City residents is examined. Such a program would require (1) use of all available resources, i.e., communications media, corporate funding, philanthropic funding, voluntary health organizations, and private hospitals; and (2) program managers to follow accepted principles of effective community organization and to adopt good management practices; to seek new ideas and implement them imaginatively; and to arouse the commitment of health professionals, politicians, parents, teachers, and policymakers. Probable program benefits are summarized in terms of school, business, and medical care settings. New York City policymakers and the New York Academy of Medicine should consider establishing a regional health center to serve as a prototype for other urban health centers and to reestablish New York City as a health education leader.

81-0310
Consumer Focus of a University Drug and Poison Information Center.
Sigell, L. T.; Piascik, M. F.; Parker, R. E.; Nelson, E. D.; and Williams, R. B.
American Journal of Hospital Pharmacy 37(9):1206-1210, September 1980.

The University of Cincinnati (Ohio) Medical Center maintains a 24-hour consumer drug-information telephone service, staffed by seven full-time employees during the week and by pharmacists and pharmacy residents of nearby hospitals during weekends and holidays. All personnel participate in structured training programs involving group and individual orientations and supervised experience. Of 40,719 calls handled in 1979, 83 percent were from the public. Total annual call volume has increased by 250 percent since 1972. In telephone followup of consumer calls, 73 percent claimed to have followed the advice given. Of calls received during 1972, 1974, 1977, and 1979, 32.2 percent concerned drug abuse; 28.6 percent concerned identification of ingredients; and 10.9 percent concerned drug efficacy. Data from a 3-month study in 1979 revealed that, in 63.6 percent of calls, the information provider's perceived goal was to satisfy caller curiosity. 3 references.

81-0311
Analysis of Health Education Sections of Health Systems Plans.
Steckler, A.; Dawson, L.; and Herndon, S.
Health Education Quarterly 7(3):186-202, Fall 1980.

A study of nine health education components of plans developed by health systems agencies (HSA's) in Region III was conducted to assess their adherence to Federal requirements that the agencies plan and provide educational opportunities for residents of their health service areas. The plans were analyzed and scored using the "Health Education Plan Scorecard," which consists of eight dimensions of the health education planning process: (1) involvement, (2) adherence to principles and practices of health education, (3) definition of problems, (4) goals and objectives, (5) recommendation of actions, (6) resources procurement, (7) implementation plans, and (8) evaluation plans. Ratings were generally higher on the first five dimensions than on the last three. The average score for all eight dimensions was 41 out of a possible 100 points, indicating that most of the HSA's had inadequate plans. Of the 18 recommendations emerging from these results, the key suggestion advocates using the scorecard as a guide during the planning-development process. 31 references.

81-0312
Drug Information for Consumers (Editorial).
Talley, C. R.
American Journal of Hospital Pharmacy 37(9):1195, September 1980.

Programs that provide drug information to consumers are operating in California, Colorado, Minnesota, and Ohio, and have experienced a large and growing demand for

their services shortly after implementation. A deficiency noted by developers of the four programs is pharmacists' lack of expertise in communication skills. Each program provides training to correct the problem, using psychological methods such as role playing, group workshops, and videotaping. In contrast to the deficiency in communication skills, the four programs have demonstrated that the answers to most consumers' questions were based on the pharmacists' own knowledge. The consumer drug-information center provides an opportunity for pharmacists to convince the public that providing drug information is the pharmacist's responsibility. 5 references.

81P-0313
East Los Angeles Community Hypertension Program.
Figueroa, D.
East Los Angeles Health Task Force, 1215 South Boyle Avenue, Los Angeles, CA 90023
Funding Source: California State Dept. of Health Services, Sacramento. Hypertension Program.
1977 - April 31, 1981.

The East Los Angeles Community Hypertension Program provides a hypertension screening, followup, and referral program to the Hispanic community of Greater East Los Angeles, a medically underserved area. Activities include blood pressure screening and monitoring at one regular site 2 days per week, outreach screening, classroom instruction on hypertension, encouragement of area health-care providers to become active in hypertension education, training in blood pressure measurement for participants in the Nurse's Aide Training Program, and training for students in the Work Experience Program. The program is coordinated with the American Red Cross, the American Heart Association, local universities and community colleges, hospitals, and clinics. The target area covers 10 cities and 79 census tracts, with a total population of 368,774, 72 percent of which is Spanish-speaking or Spanish-surnamed.

81P-0314
Health and Wellness Channel.
Schults, V. and White, P.
Community Health Education Consortium, Telecommunications Committee, W. 508 Sixth Ave., Suite 220, Spokane, WA 99204
December 1979 - Continuing.

The Health Education and Wellness Channel of Spokane, Washington, telecasts 2 hours of health and wellness programming via cable Monday through Friday nights. The channel's programming is administered by a community-based, nonprofit organization formally organized in 1977 by various health-related agencies and institutions. Activities of the telecommunications committee include previewing programs, preparing schedules, acquiring a software library, implementing publicity campaigns, and producing live programs. The target audience for a particular program can be the entire Spokane community or any specific segment with particular health-related problems or interests. The effectiveness of future programs will be measured, in part, through phone-in question and comment components.

81P-0315
High Blood Pressure Control Program.
Palmer, R.
Pico Rivera Health Center, 6336 S. Passons Blvd., Pico Rivera, CA 90660
Funding Source: California State Dept. of Health Services, Sacramento. Hypertension Program.
October 1977 - Continuing.

The High Blood Pressure Control Program is a community hypertension project that provides hypertension screening, detection, referral, and longitudinal followup. The Pico Rivera Health Center, which administers the program, serves a predominantly Mexican-American population. At the time of screening and detection, patients with elevated blood pressure receive education about hypertension, coronary risk factors, and general health maintenance principles. They are encouraged to attend a class in which hypertension is reviewed in detail through films, printed materials, and lectures. In addition, the center offers instruction in the multidisciplinary approach to hypertension control, an approach in which medical, nursing, pharmacy, nutrition, and health education students participate in hypertension control activities. The program has trained over 250 nurses in blood pressure measurement and in the significance of hypertension as a health problem. Before program implementation in 1977, no interest in hypertension control was evident within either the private or public sectors. Because of the 4,700 screenings, 455 cases of elevated blood pressure have been detected, and about 700 borderline cases have been detected. Seventy-six percent of those referred to the center have sought medical attention; most are receiving therapy.

81P-0316
High-Level Wellness Task Force.
West Tennessee Health Improvement Association, Inc., 3339 Humboldt Highway, Jackson, TN 38301
1977 - Continuing.

The High-Level Wellness Task Force promotes the principles of high-level wellness in rural west Tennessee, stressing a broad view of health in the community and increased awareness of each person's responsibility for good health. The ad hoc task force has concentrated on industrial, community, patient, and school wellness education. Program tools have included media campaigns, a speakers bureau, health fairs, well-day exhibits, an industrial wellness conference and seminar, and wellness workshops. The task force, consisting of a chairperson and 12-15 members, addresses typical problems of rural west Tennessee residents. All board members must be residents of west Tennessee.

81P-0317
Minnesota Institute on Black Chemical Abuse.
Bell, P. 111 East Franklin Avenue, Minneapolis, MN 55404
1975 - Continuing.

The Minnesota Institute on Black Chemical Abuse helps the black community develop healthy chemical use patterns, supports recovery of abusers, provides positive role models for blacks in primary treatment, and maintains community aftercare support systems. Services offered include implementing public education campaigns; providing 8-hour skills training courses for interested people in the black community and agency staff; establishing norms and standards through primary prevention activities; providing diagnosis, intervention, and treatment planning for blacks who experience chemical abuse problems; and providing group counseling. The institute also sponsors outpatient aftercare groups for blacks returning to their communities; provides individual, couples, and family counseling; provides services directed specifically towards black women; and provides outpatient treatment for black youths and their families. The youth component of the program consists of day treatment, individual counseling, parent groups, individual family counseling, aftercare planning, and group therapy for those who have ceased abusing drugs or alcohol. Although the program is directed primarily at the black community, services are available to all in need. Program achievements are evaluated by means of annual progress reports that enumerate the number of persons served in each category, allowing an examination of these figures compared with program goals. Services provided have lagged somewhat behind projected goals for counseling, aftercare, and agency training, but have exceeded projected goals in nearly all other areas.

81P-0318
Pawtucket Heart Health Program.
Carleton, R. A.
Memorial Hospital, Division of Health Education, Pawtucket, RI 02860
Funding Source: National Heart, Lung, and Blood Institute (DHHS, NIH), Bethesda, Md.
August 1, 1980 - Continuing.

The Pawtucket (Rhode Island) Heart Health Program is a 5-year project designed to develop and assess the effectiveness of a community-based effort to prevent atherosclerosis, heart disease, and stroke through risk factor reduction. Studies are being conducted in Pawtucket (the intervention city) and in a comparison city in Massachusetts. The program is based on social learning theory and utilizes the normative systems approach in which individuals redesign and modify their culture and attendant cultural norms to reach a common positive goal. Program components include self-help modules and single and multiple risk-factor group programs. Target populations include community organizations, neighborhood groups, schoolchildren, health professionals, churches, labor unions, and industries. Formative and process evaluations will assess the effectiveness of each component; the overall community impact will be determined through an outcome-oriented evaluation based on biennial surveys of adult residents of the intervention and comparison cities. Ascertainment of morbidity and mortality from myocardial infarction and stroke will be carried out in both cities, and an adequate documentation of the process and its costs will be compiled to facilitate program replication in other communities.

81P-0319
Pierre the Pelican Mailing Series.
Wight, D. M.
Nebraska Department of Health, Division of Community Health Education, 301 Centennial Mall South, POB 95007, Lincoln, NE 68509
Funding Source: Center for Disease Control (DHHS), Atlanta, Ga.
May 1972 - Continuing.

The Pierre the Pelican Mailing Series enables parents to anticipate situations and conduct and exposes them to desirable child-rearing practices and attitudes. The series is sent at no cost to the parents of all firstborns in Nebraska; currently, about 16,000 parents per month receive the series. The program is coordinated with the Maternal and Child Health Division of the Department of Health and the Nebraska Adoptive Agency Association. A formal evaluation conducted by the University of Nebraska in 1973

concluded that attitudes of participants toward children were consistent with those expressed in the series. Ninety-five percent of recipients' letters have been favorable. Comments from students and professionals have been 90 percent favorable.

81P-0320
Prevent Alcohol Abuse Through Community Education (PACE).
Peyton, C.
Santa Clara County Bureau of Alcoholism Services, Community Services Division, 976 Lenzen Avenue, San Jose, CA 95126
Continuing.

PACE (Prevent Alcohol Abuse Through Community Education), an education and prevention component of a full-service alcoholism program, is designed to provide educational experiences for low-risk drinkers in an effort to create an atmosphere in the community of San Jose, California, adverse to drunkenness and to stem the growing incidence of alcohol abuse and alcoholism. PACE staff consult with community leaders, implement mail and telephone campaigns, make presentations in the community and on television and radio, serve as consultants for parties, and appear at public events. Presentations are made on life patterning, parenting and alcohol consumption, measurement of "alcohol quotients," fetal alcohol syndrome, drinking and the family, creative entertainment alternatives to excessive drinking, selling of alcoholic beverages, attitudes and alcohol, alcohol and the modern American writer, alcohol and stress, and the use of pulque (a fermented drink) in pre-Columbian culture. The staff consists of four health education associates and one coordinator. Pre- and postintervention tests are given to residents of a target community to assess the cognitive level of awareness obtained.

81P-0321
Richfield's Health-Wellness Program.
Soba, M.
Town of Richfield, Health Officer, 5130 Hogsback Road, Hubertus, WI 53033
Funding Source: Wisconsin State Dept. of Health and Social Services, Madison.
1979 - 1981.

Richfield's Health-Wellness Program is designed to (1) make the community more aware of general health needs, (2) make the community more aware of resources available through county health agencies, and (3) expand Richfield's health resource library (which was established by the program director). Services include arranging a monthly meeting at the town hall on a health topic of community interest, preceded by community contacts to determine an appropriate topic and by promotion of the event; maintaining the health library; and placing health information on six community bulletin boards. Interest in the program's presentations and services is generated through personal and telephone contacts, letters, flyers, press releases, questionnaires, and visits to schools. The target population consists of the 8,000 residents of Richfield, Wisconsin. Cooperating agencies include county home extension programs, local schools, the sheriff's department, the Red Cross, county health agencies, Scout troups, and 4-H clubs. The monthly health presentations are evaluated through forms filled out by participants; attendance generally runs from 60 to over 150 persons.

81P-0322
Stavros Foundation, Inc.
691 South East St., Amherst, MA 01002
Funding Source: Executive Office of Human Services, Boston, Mass. Massachusetts State Rehabilitation Commission.
1974 - Continuing.

The Stavros Foundation is a nonprofit, community-based, consumer-controlled advocacy organization working to facilitate independent living for people with severe physical disabilities. The foundation's activities include peer advocacy and counseling, general advocacy services, information and referral services, consultation services, and technical assistance. Individual and group counseling sessions focus on understanding disabilities, communication skills, personal care, finances, architectural accessibility, housing, transportation, legal services, education, employment, and human relations. Peer modeling is central to all counseling services. Communities and individuals in Hampden, Hampshire, and Franklin Counties, Massachusetts, are served.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-0323
Why Your Organization Should Consider Starting a Physical Fitness Program.
Conrad, C. C.
Training 16(2):28, 31, February 1979.

The benefits of implementing employee fitness programs are discussed. Program components should emphasize (1) physical fitness attainment as the primary goal, via activities that develop muscular strength and endurance, cardiovascular endurance, flexibility, and balance; (2) individualized exercise and education assessments, and seminars and private consultations on smoking, obesity, and alcoholism; (3) the absence of participant competitiveness; (4) scheduling during work hours, for reasons of motivation and supervision; (5) incorporation with the company medical program, with all prospective participants obtaining medical clearance; (6) establishment of medical emergency procedures; (7) supervision by a qualified physical education instructor; and (8) management participation, to provide an example for employees.

81-0324
Corporate Health: A Result of Employee Fitness.
Martin, J.
Physician and Sportsmedicine 6(3):135-137, March 1978.

Recent employee fitness programs initiated by large companies have involved large outlays of money and large staffs, the latter including physicians, exercise physiologists, nurses, dietitians, and other health personnel. For example, the Sentry Insurance Company at Stevens Point, Wisconsin, has a full-size gym, a 25-meter swimming pool, strength-building equipment, and other exercise equipment. Other large-scale fitness programs are operated by the Northern Natural Gas Company of Omaha (Nebraska) and the Kimberly-Clark Corporation of Neemah, Wisconsin. The comprehensive health education program at the Sentry Insurance Company is supervised by two physicians and by support personnel. The annual meeting of the American Association of Fitness Directors in Business and Industry drew more than 150 delegates last fall, compared with an attendance of 55 at the first convention 2 years ago. The association has more than 300 members and receives an average of 20 letters per week from firms wanting to start fitness programs.

81-0325
Encouraging New Lifestyles: PLUS Puts It All Together.
Swift, C.
Journal of Prevention 1(1): 44-46, Fall 1980.

The Program to Lower Utilization of Services (PLUS), administered by the Kansas Department of Health and Environment to lower the health risks of workers, comprises seven program options designed to reduce stress, accidents, alcohol abuse, overeating, and smoking, and to improve physical fitness and dietary habits. PLUS acts as a broker in networking health and mental health professionals with a committee of workers and managers from the sponsoring agency in order to implement selected interventions. Clients are grouped together to reinforce each other and maintain participation through every phase of intervention. Though PLUS attracted only 50 percent of the health department's employees in a pilot program, participants experienced great success in changing their lifestyles. In addition to using peers for social reinforcement, PLUS provides individual interpretations of test results by professionals, periodic self-assessment, and sponsors and administrators recruited from the local community. By networking volunteers, programs have been implemented at no cost for 723 persons in 5 settings.

81-0326
A Vital Link in an Employee Health Program.
Thomas, M. R.
Occupational Health and Safety 49(5):52-53, 55, May 1980.

The need for cancer education and screening programs in the workplace is discussed. Many occupational health professionals share the prevailing pessimistic attitude of the public toward cancer and remain unaware of positive measures employees can take to protect themselves. The "Seven Safeguards," i.e., the American Cancer Society's recommended actions for individual protection from common cancer forms, and the "Seven Cancer Warning Signals" can constitute the essential element of an employee cancer-control program. Programs can be as basic as offering an information campaign utilizing the company's communication network, or as extensive as offering cancer screening tests through scheduled employee physical assessments. Cancer indirectly costs the employer, and this fact can be used to "sell" cancer-control programs to top management. The occupational health professional can provide employees with the education needed to know that personal action can be taken to prevent cancer or detect it early. 7 references.

81-0327
An Ounce of Prevention...
Wheeler, C.
Occupational Health and Safety 49(5):58-59, 66, May 1980.

Since 1979, Milwaukee Industrial Clinics has offered structured health promotion programs to client industries. Programs include (1) three classes in cardiopulmonary

resuscitation and first aid, designed to result in certification of all participants; (2) an industrial dermatitis seminar, which examines predisposing factors and direct causes; describes high-risk industries and their economic impact; and covers treatment, rehabilitation, and preventive measures within the legal framework; (3) a course on the prevention and management of back problems and injuries, which includes an overview of the static and dynamic spinal anatomy and emphasizes common work-related back injuries, emergency treatment, early intervention, and prompt rehabilitation; (4) a look at the troubled employee, which examines a cost-effective health care plan, an employee assistance program, and a description of treatment modalities; and (5) a discussion of stress in the workplace, which examines emotional stress and its direct and indirect effects on safety and productivity, and includes practical suggestions for stress management.

81P-0328
Bridgewater State College-Fall River Firefighters Fitness Program.
Fields, S. and DuBois, P.
Massachusetts Department of Public Health, Division of Preventive Medicine, 600 Washington Street, Boston, MA 02111
Funding Source: Center for Disease Control (DHHS), Atlanta, Ga.
Continuing.

The Bridgewater State College-Fall River Firefighters Fitness Program is a worksite health promotion program to improve or maintain the health status of firefighters and to develop an employee program which improves physical fitness, is acceptable to firefighters, and is cost effective. Services include (1) physical and health risk analysis and (2) health promotion services, including counseling, educational seminars, an exercise program, and a quarterly review and followup to determine participant compliance. The target audience consists of firefighters from the Fall River, Massachusetts, Fire Department. Onsite fitness counseling is provided by physical fitness students from Bridgewater State College. Evaluation methodologies include pre- and postprogram measurement of medical data; health hazard appraisal; the use of sick leave, insurance, and disability payments; quarterly progress reports for each client and for the total population; and assessment of the success and acceptability of student fitness counselors.

81P-0329
Department of Public Health Employee Fitness Program.
Fields, S.
Massachusetts Department of Public Health, Division of Preventive Medicine, 600 Washington Street, Boston, MA 02111
October 1980 - October 1981.

The Massachusetts Department of Public Health Employee Fitness Program is designed to improve or maintain the health status of department employees and pilot test proposed policies and procedures for a broad-based State employee program. The comprehensive health promotion and physical fitness program will offer physical and medical testing and health risk analysis services to employees to derive base-line data. Once the data are assessed, an individual health plan will be formulated for each employee. Subsequent health promotion services available to the employee will include private counseling, education seminars, organized exercise programs, and followup reviews of accomplishments. In addition to health risk appraisal, nutrition analysis techniques, and physical and medical examinations, the program will employ personal contracting techniques to enhance client cooperation. Of the 700 Department of Public Health employees in the target audience, it is estimated that over 250 will take part in the pre- and postprogram physical examination and health risk analysis. At least 50 of these participants will participate in the organized exercise component of the program. If successful, the project will be replicated for other State employers. Evaluation methodologies include pre- and postprogram assessments of medical data, health risk factors, absenteeism due to illness, and insurance and disability payments; quarterly progress reports for each client and for the total population; and assessment of employee acceptance of the program.

81P-0330
Health Choices.
Jones, R.
Blue Shield, Ohio Medical Indemnity Mutual Corporation, 6740 North High Street, Worthington, OH 43085
Continuing.

Health Choices is a comprehensive health promotion and education program for employees and their spouses. The program, which is designed to run over an 18-month cycle, includes a health screening period to formulate base-line health appraisal data on each participant and the community as a whole, followed by a series of seminars and courses to encourage healthier lifestyles. Screening programs are offered for hypertension, cancer, and glaucoma; seminars and workshops are offered on health risk factors, physical fitness, stress management, nutrition, safety, and alcohol abuse. Health and lifestyle courses address physical fitness, smoking cessation, diet and nutrition, cardiopulmonary resuscitation training, and first aid.

The program also offers consulting services about community resources, fitness trails, and exercise rooms. Teaching aids used to supplement courses and seminars include books, booklets, and multimedia presentations. The program is available to all companies in Ohio from local Blue Cross-Blue Shield representatives, regardless of whether the businesses carry Blue Cross-Blue Shield health insurance. A health status survey, which is used to gather data to support an action plan for improving the target group's general health, establishes base-line data for measuring change through future surveys.

81P-0331
Sentry Physical Fitness-Wellness Program.
Jones, L. D.; Johnson, D. D.; and Cook, R. J.
Sentry Corporation, 1800 North Point Drive, Stevens Point, WI 54481
Continuing.

The Sentry Physical Fitness-Wellness Program encourages employees to maintain high level wellness. The program (1) operates a physical fitness center featuring a 25-meter pool, a full-sized gymnasium, two racquetball and handball courts, and a large exercise area; (2) provides a "quiet room" for employees wishing to "seek refuge," meditate, or pray; (3) offers weight-control programs and information on general dietary principles; (4) offers 5-day stop-smoking clinics with followup reinforcement meetings; and (5) distributes materials on responsible alcohol use, stress management, and the importance of blood fat levels. Employees can arrange with their supervisor for work-schedule adjustments that allow use of the center any time during the workday. Program facilities are open to each of the 2,400 Sentry employees, and their spouses, dependents, and significant others, as well as retired employees. The center receives about 2,400 visits per week, and the overall wellness program has proven a valuable tool in recruiting and retaining employees.

81P-0332
Swedish Wellness Center.
Adamson, G. J.
Swedish Medical Center, 501 East Hampden Avenue, Englewood, CO 80110
1977 - Continuing.

The Swedish Wellness Center (SWC) was developed to improve the health of Swedish Medical Center employees and clients and to encourage a wellness perspective in all health care providers. Using a community resource broker model, the SWC is primarily involved in the health assessment of individuals and groups, in the wellness program design based on these assessments, and in the evaluation of overall program effectiveness. Services provided by the employee program revolve around three currently available plans and one plan to be offered in the future. These plans involve lifestyle courses, individual contract counseling, workshop activities, publication of a monthly newsletter, use of the Swedish-Craig Fitness Center for fitness programs, and use of library services. The program has also provided a number of health care professional groups with inservice education in personal and professional aspects of wellness. In December 1978, a school-based program concentrating primarily on faculty inservice training was implemented. The center also provides technical assistance to schools and parent organizations in the design of health education curricula based on wellness models. A business and industry wellness program is currently being designed. Although the primary target population has been the center's employees, a second program has been implemented for the general community served by the Swedish Medical Center. The center has 7 full-time staff members and uses the services of approximately 50 community resource persons on a contractual or retainer basis. A pilot employee program begun in May 1978 demonstrated, through pre- and postprogram assessments, that employees who completed all elements of the program experienced significant positive changes in each of the wellness component areas.

81P-0333
Worksite Blood Pressure Program.
Glynn, C. W.
New York State Department of Health, Office of Public Health, Tower Building, Governor Rockefeller Empire State Plaza, Albany, NY 12237
January 1980 - Continuing.

The Worksite Blood Pressure Program is a mass media informational campaign to encourage New York State employers to implement hypertension control programs at the worksite. Before the campaign began, health care organizations throughout the State were requested to assist in the effort, and program development training was provided for State Department of Health staff, volunteer groups, and for health care groups under contract with the department. Services include mailings to businesses, labor organizations, business periodicals, Kiwanis and Rotary clubs, chambers of commerce, minority businesses, employers with Blue Cross-Blue Shield coverage (these mailings were conducted by Blue Cross-Blue Shield), health departments, and pharmacists; production of bilingual transit cards; production of radio and television public service announcements; and consultation with employers who want to establish programs. Consultants try to tailor

the program to the company's size, facilities, and resources. Since the program began, about 200 worksite screening or treatment programs have been implemented. As the program proceeds, data will be collected on the number of requests received, programs implemented, and employees screened or treated; final usage figures for radio and television public service announcements; demand for educational materials; and sources of information requests. Print materials will be evaluated by health professionals. The State Department of Health also responds to requests from out-of-state health departments and health organizations.

HEALTH EDUCATION METHODOLOGY

81-0334
Marketing Yourself and Your Program.
Brown, S.
AARN News Letter (Edmonton) 36(7):1-6, July-August 1980.

Marketing health education programs to emphasize the long-term benefits of behavioral change is examined. The advantages of marketing are its noncoercive approach to change, its pervasiveness, and its proven effectiveness as a change agent. The four elements of marketing are the program, price, promotion, and place. Marketing research binds these four elements together. The first step for any marketer is problem recognition, the second involves formulating realistic program objectives, and the third consists of program definition based on a market research program of target audience characteristics and needs. In program implementation, funding problems might necessitate the use of publicity (such as news releases) rather than advertising. Following program design and implementation, an evaluation is necessary and can be used in changing marketing objectives, segment, or strategy.

81-0335
Free Hypertension Resources: An Annotated Bibliography.
California Hypertension Information Clearinghouse, Sacramento.
Sacramento, Calif., the Clearinghouse, 38 p., May 1980.

An annotated bibliography of free educational materials relevant to hypertension control is offered for health educators and providers. Books, booklets, pamphlets, posters, selected reprints, and audiovisuals are included.

81-0336
Trends in the Organization of Health Education: Implications for Training in Developing Countries.
Carlaw, R. W.; Ross, H. S.; Poerbonegoro, S.; and Soetjahja, I.
International Journal of Health Education (Geneva) 23(2, Suppl.):1-14, April-June 1980.

Trends in health education in the developing countries of Indonesia, Papua New Guinea, and Nepal suggest the eventual formation of a system of education for health behavior. The methodology employed to collect and analyze data was largely anthropological. Though the three countries share no ethnic, political, or religious influences, the population of each is affected by malaria, gastroenteric disorders, intestinal parasites, malnutrition, acute communicable diseases, tuberculosis, leprosy, and overpopulation. In responding to these problems, each country initially employed villagers with limited training to provide health education. While Nepal remains at this stage, Papua New Guinea has proceeded to a second stage, involving the use of paramedics and professionals who have bachelor of science degrees. Indonesia has progressed to the third stage, which involves use of professionals with postgraduate training. In the first stage, health education is informational, and the educator has a close cultural identity with the target population. The "diploma," or second stage, is an extension of the information stage, but is removed from the people and, therefore, less effective. The third stage, in which the specialist predominates, does not meet the expectations of politicians and administrators due either to the complexity of the task or to the inadequacy of professional training. The social science practitioner must deal with these problems. 6 references.

81-0337
Teaching Nutrition With Magic.
Fishman, P. B.
Journal of the American Dietetic Association 77(5):580-582, November 1980.

Experiences of a nutrition educator in Sunset Park in Brooklyn, New York, indicate that using magic and other show business techniques can facilitate the learning processes associated with community nutrition education. Children exposed to nutrition principles and practices through the medium of a magic act responded enthusiastically and retained their interest in the teaching method and the subject matter for several days. 3 references.

81-0338
Practical Multiple-Choice Exams.
Fox, R. A.
Journal of School Health 50(9):514-516, November 1980.

Constructing multiple-choice tests on health topics involves design development, item construction, and item analysis and evaluation. When designing a multiple-choice test, the educator must analyze the knowledge to be measured, dividing the subject matter of the teaching unit into major topic areas and emphasizing each area according to its importance. Teachers should be sure that test directions and questions are clear and that items test an understanding of important concepts rather than trivial facts. It is good educational procedure to grade and return a test to the class at the first meeting after the test is taken; this gives the students an opportunity to discuss the exam while the experience is fresh in their minds. 5 references.

81-0339
Computers and Health Education.
Gold, R. S. and Duncan, D. F.
Journal of School Health 50(9):503-505, November 1980.

A survey was conducted of 95 schools with programs included on the Association for Advancement of Health Education's list of programs in health education. The survey revealed that only 18 schools used computers in their departments, indicating a need to inform health educators of the potential applications of computers. Computer techniques can be used by managers, educators, and researchers in health education. In the field of education, the computer can act as an aid to instruction, as an instructor, and as a classroom management tool. 5 references.

81-0340
Educational Strategies to Improve Compliance With Therapeutic and Preventive Regimens: The Recent Evidence.
Green, L. W.
In: Compliance in Health Care. Haynes, R. B.; Taylor, D. W.; and Sackett, D. L., eds. Baltimore, Md., Johns Hopkins University Press, p. 157-173, 1979.

A review of recent developments in health education research was conducted to determine means by which health education can maximize its contribution to health care. For health education to effect a lasting behavioral change, three factors must be present: (1) a motivational or predisposing intention, (2) an enabling factor such as the awareness of a service or program, and (3) reinforcing support from the community. Recommendations are offered for incorporating the strategies of behavior modification, health counseling, motivation, and communications strategies. In addition, practical health education recommendations to improve comprehension, recall, and compliance are given, based on the principles of brevity, organization, primacy, readability, repetition, and specificity.

81-0341
Effective Public Education for Achieving Oral Health.
Horowitz, A. M. and Frazier, P. J.
Family and Community Health 3(3):91-101, November 1980.

In response to the limitations of current approaches to public dental health education, a number of health education priorities for social action have been formulated. Some factors contributing to the ineffectiveness of current education include failure to involve community and school leaders in defining community problems and developing appropriate solutions, inadequate program objectives, inadequate dissemination of accurate information, single presentations of information with little or no follow-up, inadequate long-term supervision and evaluation of oral hygiene procedures, inconsistencies between children's environments and the information taught about diet and other dental health factors, and inadequate followup of screening and referral procedures. Recent innovative programs have encouraged active participation by children, promoted brushing and flossing to remove plaque, promoted the use of fluorides and reduction in sugar consumption, and provided followup to ensure that children have access to professional dental care. In community oral health programs, community leaders, schoolchildren, and adults should all be informed about preventive measures. Community-wide programs should involve establishing a group representing various agencies and organizations, helping consumers conduct surveys to identify public perceptions, initiating seminars to inform community leaders, and helping professionals update their knowledge. 23 references.

81-0342
Use of Media in Lifestyle Programs.
Maccoby, N. and Alexander, J.
In: Behavioral Medicine: Changing Health Lifestyles. Davidson, P. O. and Davidson, S. M., eds. New York, Brunner-Mazel, p. 351-370, 1980.

Two types of community-based cardiovascular disease prevention programs were assessed. The programs attempted to generate behavioral, knowledge, and attitudinal changes through mass media alone and on the entire sample through a combination of mass media and intensive personal instruction on a subsample of high-risk subjects. The media campaign consisted of television spots and programming; radio spots and programming; newspaper advertisements, columns, and stories; billboards; and printed material sent to participants. As expected, the mass media programs supplemented by personal instruction resulted in substantial overall risk reduction; however, in many instances media efforts alone were successful. Results suggest that certain risk-reduction behaviors can be learned through media exposure, while others require a constellation of media events that offer skills training (e.g., cigarette smoking cessation). Implications of these results are discussed. 29 references.

81-0343
Audiovisual Aids for High Blood Pressure Education.
National High Blood Pressure Education Program (DHEW, NIH), Bethesda, Md.
Bethesda, Md., National Institutes of Health (NIH Publication No. 80-1663), 195 p., October 1979.

Audiovisual aids pertaining to high blood pressure, for use by health professionals, are listed. Titles were chosen according to national availability, a post-1973 production date, and a hypertension-specific topic. Public service announcements on high blood pressure are not listed. Categories include materials for public, patient, and professional education. The professional education section is subdivided into subject-area categories. Appendices list every entry alphabetically by title, format, and producer.

81-0344
Health Activation for Senior Citizens: A Course Guide.
Nocerino, J. T.; Pringle, W. B.; and Sehnert, K. W.
Rev. ed. Vienna, Va., Health Activation Network, 215 p., 1977.

Guidelines are provided for health activation coordinators and facilitator-teachers who work with the elderly. The health activation course consists of seventeen 2-hour sessions, each of which emphasizes individual rights and responsibilities, self-care, and self-help. Sections include a course guide overview; an overview of health activation; the elderly as health-activated persons; tips for health activation program coordinators and facilitators; detailed session plan outlines; a list of handout sources; and handouts available for reproduction.

81-0345
Teaching--Learning Strategies.
Peters, V. J.
Diabetes Educator 6(2):23-24, 26, Summer 1980.

Formulation of behavioral objectives for a diabetes education program provides specific criteria for measuring results of teaching and creates a basis for program accreditation. Confusing the objectives of the learner with those of the teacher, however, confuses the direction of learning. Vague, general objectives should be reformulated into a specific, concrete delineation of expected learner performance, conditions under which such performance is to occur, and criteria of acceptable performance. Only observable activities should be described in each statement of an objective. General objectives can be used in conjunction with a cluster of specific objectives, but the latter should be carefuly and concretely delineated. Use of several different action verbs in the statement of a behavioral objective can make the statement too complex to use in evaluation efforts. Overall, statements of behavioral objectives should be clearly distinguishable as either learner or teacher objectives, highly specific, and simple. 8 references.

81-0346
Selected Sources of Instructional Materials: A National Directory of Sources of Instructional Materials in Health Education, Patient Education, and Safety Education.
Pigg, R. M., Jr., ed.
Muncie, Ind., Eta Sigma Gamma, 54 p., 1980.

A list of organizations, agencies, and businesses offering materials related to health sciences and safety is offered. Free or inexpensive materials include pamphlets, books, charts, posters, slides, films, filmstrips, records, photographs, transparencies, and spirit masters; numerous commercial materials available for purchase are also listed. Sources are organized into five general categories: (1) voluntary and professional; (2) commercial and sponsored; (3) patient education; (4) Federal Government; and (5) audiovisual.

81-0347
Mental Health Education.
Roscher, C. I.
Curationis (Pretoria) 1(4):51-52, March 1979.

The chief barrier to effective mental health education, particularly in South Africa, is poor interpersonal communication. The multicultural nature of the society demands sensitivity and respect for many cultural norms.

The educator must carefully consider justifications for leaving certain cultural values unchanged or, when making changes, must know how to do so with a minimum of interference. Since environmental factors like high-density living, lack of privacy, oppressive heat, or excessive noise often contribute to mental disease, a multidisciplinary approach, involving architects and town planners as well as psychiatrists, social workers, and psychologists, should be taken in mental health education. 4 references.

81-0348
Evaluating Nutrition Education Curricula: New Strategies-Alternate Methodologies.
Talmage, H.
Health Education 11(5):14-18, September-October 1980.

The sophistication of nutrition education curricula and the selectiveness of teachers and administrators in approaching such curricula demand equally sophisticated and rigorous evaluation designs. Since nutrition programs must effect changes in attitudes and behavior rather than simply promote knowledge acquisition, classical research designs measuring only knowledge acquisition are inadequate. Problems confronting the evaluator using the classical methods of evaluation (pre- and posttest--experimental versus control) include failure to measure the teacher's implementation of the program as designed by the nutrition educator, failure to consider individual variation within experimental and control groups, lack of long-term followup, lack of evaluation of extracurricular influences, and failure to account for unanticipated effects. To avoid these problems, the evaluator should observe classroom activity, interview and test the teacher, require the use of teacher logs, consider influences (home, ethnic, and peer pressure) affecting food choice, conduct periodic followup studies, use archival data (such as school-lunchroom purchase orders) as a source of followup material, obtain data from as many sources as possible, and maintain close observational contact with the school and the community to assess unintended influences on the students. 13 references.

81-0349
Regional Rural Genetics Program: Educational Considerations.
Wertelecki, W.
Progress in Clinical and Biological Research 34:53-65, 1979.

In 1978, the Alabama State Government funded a regional genetic program, an effort to identify families with genetic disorders, encourage preventive measures, encourage genetic counseling and amniocentesis, and develop an educational program for physicians and the public. The University of Alabama medical school was the focal agency. Links with existing State organizations and rural areas included a physician who directed a large public health department, a member of the Association for Retarded Citizens, a health planner familiar with all chapters of the March of Dimes, and a former director of the State Special Education Department. These consultants selected the candidates who became members of a multidisciplinary advisory board; they also scheduled regional leadership briefings. The medical school's Rural Family Practice Program, which regularly sends interns to rural hospitals, offered established channels for a genetic program aimed at rural colleagues. In addition, a team of psychiatrists, geneticists, and educational psychologists was formed, and a program was initiated that required each medical student to obtain one family history per day during rural rotation. Other components of the program included an educational effort aimed at public health nurses, a public speakers program, a miniresidency in genetics for rural practitioners, a letter campaign to promote incorporation of genetics into high school curricula, and a research project focusing on 1,000 teenage mothers. 2 references.

PATIENT EDUCATION

81-0350
Patient Education: Does It Take More Time?
Bartlett, E. E.
Physician's Patient Education Newsletter 3(5):1, October 1980.

In informal observations of clinical procedures, it was noted that physicians are usually silent during most of the physical examination process, neglecting opportunities to educate and examine concurrently. The patient teaching done by most physicians in relation to regimen was diffuse, excessively detailed and complex, and repetitive. Physicians often failed to respond to the behavioral needs of patients, which could be done by educating patients about disease processes rather than proper responses to disease. Good patient education often takes no additional time in the short run and, for many conditions, will save time in the long run. 1 reference.

81-0351
Patient Education Through Record Sharing.
Bronson, D. L.; Rubin, A. S.; and Tufo, H. M.
QRB: Quality Review Bulletin 4(12):2-4, December 1978.

The Given Health Care Center at the University of Vermont has adopted the problem-oriented medical record (POMR) to link physician action, including patient education, to individual health problems. The center's method of record sharing begins with the patient's initial health examination, after which the physician discusses with the patient particular goals related to each active and potential health problem. Specific education and medical plans for each problem are then formulated. These goals and plans are written in lay language, and a copy is sent to the patient with instructions on how to read the record and how to "audit" its contents. Of 3,400 sequentially chosen patients who received their records, 19.6 percent returned their audit form. Responses were organized into three categories: information corrected; progress reported in meeting goals; and additional information supplied or questions asked. Each response was reviewed to determine if a change in plans or problem statement was necessary. Results of experiences with record sharing indicate that center patients have benefited from record sharing and patient audit, and that such participation fosters respect between physician and patient. Implications of these results are discussed. 3 references.

81-0352
Patient Counseling vs. Patient Teaching.
Hochbaum, G. M.
Topics in Clinical Nursing 2(2):1-7, July 1980.

Factors that should be considered when implementing a patient education program are examined. Topics include (1) program caliber, including the effectiveness of a core group of skilled patient educators; (2) the temptation of health professionals to blame poor compliance on the assumption that human behavior is shaped by rationality and motivation, the lack of which fosters poor compliance; (3) causes of poor compliance, including the patient's degree of suffering, outside influences, lack of patient information, social and economic barriers, conflicts between the medical advice a patient receives and work environment demands, and barriers in the home environment; and (4) means for improved program effectiveness, including the act of listening and questioning by the health educator; avoidance of compromising medical regimens when patient adherence barriers are encountered; provision of more attention to patients on an individualized basis; and exhibition of greater understanding of the patient's rationality, mentality, and problems. 1 reference.

81-0353
Overcoming Fear: The Pre-Operative Visit.
Hughes, J.
Nursing Times (London) 75(42):Suppl. 4-6, October 18, 1979.

At least five different professionals come into contact with every preoperative patient, yet none of them are likely to listen to the patient's worries. Since preoperative visits should help patients overcome fear of the operation, a member of the surgical team can be most effective for this type of visit. The theater nurse, as part of the surgical team, can provide the patient with compassionate and professional assistance from the time of admission to the surgical ward through the surgical procedure itself. In cases requiring minor surgery, group education sessions taught by a ward nurse are often helpful. Major surgery, however, demands a more intimate approach and the specific knowledge of the theater nurse. The same nurse that conducts the preoperative visit should be present in the recovery room to discuss any questions that might arise.

81-0354
Patient Teaching Assignment.
Jones, N. H.
Virginia Nurse Quarterly 46(2):15-16, Summer 1978.

A case study of a patient education program for a woman suffering from cirrhosis of the liver reveals the rewards of a properly planned and executed teaching format. The three goals for the patient-teaching assignment were to help the family assure that someone would check on the patient's well-being at least twice daily, to help the patient and her family implement the prescribed diet, and to provide support to the patient and her family so that she could stay at home for at least 3 weeks between hospital admissions to treat bleeding from the esophageal varices. The nurses in charge of patient education contacted community workers to provide home visitation services, met with family members, planned menus with the patient and the members of the family who did the shopping for the patient, and made weekly home visits. These nursing interventions enabled the patient to control her condition to the point that hospitalization was no longer necessary. Essential to the success of the nurse-educator's program was the fact that the patient was treated as a responsible adult who could make her own decisions. 4 references.

81-0355
A Complex Home Management Need: One Teaching Approach.
Kissel, C.
Nursing Administration Quarterly 4(2):17-20, Winter 1980.

The first step in self-care instruction for patients with hematological disorders is to define five patient behaviors necessary to accomplish deferoxamine treatment: (1) the patient or a significant other stating deferoxamine use, dose, schedule, side effects, and administration; (2) the patient or a significant other demonstrating sterile subcutaneous injection technique with a butterfly needle by drawing 5cc of saline; (3) the patient demonstrating operation of autosyringe pump and stating actions necessary for pump repair or parts replacement; (4) the patient demonstrating sterile technique in diluting deferoxamine and its proper storage; and (5) the patient stating the complications that require contacting the medical staff. The nurse's role in accomplishing each of these objectives is outlined.

81-0356
A Simple Yet Successful Way to Help Your Patients Plan Their Own Diets.
Lichtman, T.
Journal of the American Dietetic Association 77(5):582, November 1980.

Color-coded labels, made from simple materials, can serve as visual aids in teaching nutrition principles to patients and as aids in evaluating educational results.

81-0357
To Learn...To Teach...To Grow.
Marcuz, L.
Diabetes Educator 6(2):16-18, Summer 1980.

A teaching plan that emphasizes trust between the newly diagnosed juvenile diabetic and the educator is outlined. Through an initial interview, the patient is made to feel comfortable and encouraged to be open with the educator so that an effective assessment and educational plan can be developed. The teaching plan should encompass (1) the patient's level of understanding, including age level, emotional level, reading and comprehension skills, independence, and maturity level; (2) an assessment of tasks patients can learn; (3) time assessment, including the number of daily sessions, session timespan, time for parent education, and projected length of hospital stay for educational needs; and (4) use of an educational flowsheet and coordination of its use with floor staff. The child's understanding level can be evaluated by return demonstrations and by demonstrating tasks learned to parents. Teaching aids and the importance of the family interview and family reinforcement of knowledge levels are discussed.

81-0358
The Process of Patient Teaching in Nursing.
Redman, B. K.
4th ed. St. Louis, Mo., C. V. Mosby, 291 p., 1980.

Information for nurses interested in the patient-teaching process is provided. Topics include the place of teaching in nursing; an overview of the teaching-learning process; readiness for health education; objectives of health teaching in nursing; learning theory and principles; a definition of teaching, teaching theory and interpersonal teaching techniques; printed and nonprinted teaching materials; planning and implementation; evaluation of health teaching; present delivery of patient education; and directions and development in patient education delivery. Several case studies, teaching examples, and questions on patient teaching are appended. Numerous references.

81P-0359
Closed Circuit Television Patient Education.
Ford, D.
Mercy Regional Medical Center, 100 McAuley Drive, Vicksburg, MS 39180
Continuing.

The Closed Circuit Television Patient Education program at Mercy Regional Medical Center in Vicksburg, Mississippi, offers videotaped programs on health topics to reinforce the teaching of nurses and physicians and to educate the general population. A variety of short presentations is available free of charge Monday through Friday to the hospital population, visitors, and outpatients. The presentations will be available 7 days a week, 24 hours a day, after an automated system is introduced. Patients are informed of the service through program guides in their rooms, recommendations by nurses or physicians, posters throughout the hospital, and local newspaper advertisements. About 75 percent of the hospital population views at least one program, and half of all patients watch the channel with a visitor; in all, the channel reaches 5,000-6,000 persons per year. Physicians have been fully cooperative. Presentations are reviewed by a registered nurse, who consults physicians and nurses for additional evaluation.

81P-0360
Let's Talk About the Hospital.
Gray, T. and Cox, B.
Family Communications, Inc., 4802 Fifth Avenue, Pittsburgh, PA 15213
Funding Source: Johnson & Johnson Baby Products Co., Piscataway, N. J.; McFeely-Rogers Foundation, Latrobe, Pa.
1974 - Continuing.

"Let's Talk About the Hospital" is designed to reduce the stress of hospitalization for young children. The program was developed and is offered by Family Communications, a private, nonprofit organization. The packaged program includes three videocassettes, three children's booklets, a parents' booklet, three posters, a hospital staff booklet, and an introductory workshop. The videocassettes address stresses children feel when visiting the hospital, wearing a cast, or having an operation. The package is offered in whole or in part on a fee basis to any hospital. Package development consultants have included the patient representative at Children's Hospital National Medical Center in Washington, D.C., 10 physicians, 2 registered nurses, and 10 other individuals with either master's or doctorate degrees. Materials for the package were developed in cooperation with the American Academy of Pediatrics, the American Hospital Association, and the American Medical Association. Pilot versions of the program have been successfully tested in over 30 hospitals in the United States and Canada. Hospital staff responses indicate that the programs can be extremely valuable in the emotional preparation of children up to the age of 10 years. The programs are particularly suitable for preschoolers.

81P-0361
Patient Education and Health Promotion.
Soghikian, K. and Squyres, W.
Kaiser-Permanente Medical Care Program, Northern California Region, 3451 Piedmont Avenue, Oakland, CA 94611
Continuing.

The Patient Education and Health Promotion program is designed to (1) help people focus on the actions they can take to protect and maintain their health, (2) help disabled persons find creative ways to accomplish previously difficult tasks, (3) help patients handle the nutritional aspects of their treatment, and (4) help people quit smoking and cope with social and work situations. Kaiser-Permanente, which administers the program, is a prepaid, group-practice, health-care-delivery system. Services include amniocentesis, baby care classes, back care groups, cancer counseling and information services, closed-circuit television programming for hospital patients, coronary education classes, diabetes groups, diabetes team teaching for juveniles, enterostomal therapy, family planning discussion groups, health counseling, health library services, home blood pressure instruction, hypertension classes, insulin injection instruction, and Lamaze classes. The program also includes lipid education groups, counseling and information services for patients who have undergone heart surgery, pregnancy and abortion counseling, prenatal classes, prenatal orientation groups, meetings between expectant couples and residents on the obstetric service, respiratory care classes, smoking cessation clinics, tubal ligation groups, vasectomy groups, an international venereal disease hotline, health promotion courses, cardiopulmonary resuscitation classes, nutrition education classes, relaxation classes, parent-effectiveness training classes, stress reduction classes, menopausal adjustment classes, and classes on aging parents. Services are available to the Kaiser-Permanente's northern California region, consisting of 13 hospital-based medical centers and 6 outpatient medical office complexes; 1.7 million people are served by the program. Health educators employed by the program include physicians, nurse practitioners, registered nurses, dietitians, physical therapists, and pharmacists. Between 20 and 30 instructors conduct formal patient education programs at each medical center.

81P-0362
University of Alabama-Birmingham Health Education Program.
Bartlett, E. E.
University of Alabama-Birmingham, School of Medicine, Department of Family Practice, University Station, Birmingham, AL 35294
Funding Source: Bureau of Health Professions (DHHS, HRA), Hyattsville, Md.
July 1980 - Continuing.

The Health Education Program at the Department of Family Practice, University of Alabama-Birmingham, is based on the premise that (1) patient education is an intrinsic part of high-quality medical practice; (2) the basis of effective patient education is a good provider-patient relationship; and (3) patient education should influence the patient's health behavior, rather than merely increase the patient's knowledge. Program contents include (1) observation of clinic residents during patient care; (2) reinforcement of patient education activities by attending physicians; (3) instruction on such topics as behavioral diagnosis, smoking cessation, and preventive medicine; (4) monthly reviews regarding the recording of patient education as an element in the medical chart; and (5) special activities and projects undertaken by faculty, residents, and staff members of the Health Education and Prevention Committee. Program evaluation is based on chart audits and telephone interviews with patients regarding their satisfaction, understanding of the regimen, and regimen adherence. An evaluation of patient education activities will be incorporated into an overall evaluation of the residency training program.

PROFESSIONAL EDUCATION AND TRAINING

81-0363
Teaching Medical Students to Stay Healthy.
Goldsmith, G.; Ngissah, K.; and Woolsey, J.
Western Journal of Medicine 132(3):251-252, March 1980.

"Health Promotion for Medical Students and Their Patients," an elective course developed by the Department of Family Practice at the University of California at Davis for second-year medical students, is examined. The course begins with a thorough health inventory of each student, including diet, stress level, fitness, health risk assessment, and psychological status. The resulting profile is used to formulate individual student health prescriptions for relaxation, stress reduction, dietary improvements, exercise programs, and weight reduction. A health educator works with each student, and students have an opportunity to practice what they have learned with a patient or family. Upon class completion, students are reassessed. Overall, the course provides opportunities for students to practice healthful behavior, preparing them to play a significant role in patient health maintenance.

81-0364
Health Education in Medical Education: Teaching the Physician-Patient Relationship.
Grayson, M.; Golden, A.; Baile, W.; and Barker, L. R.
Physician's Patient Education Newsletter 3(5):8-9, October 1980.

Recent studies have demonstrated that the technical nature of modern medicine and the resultant lack of personal interaction between patient and physician have contributed to poor patient compliance with prescribed regimens. In response to this problem, the primary-care residency program of Johns Hopkins University School of Medicine at Baltimore City Hospital trains residents in the knowledge, attitudes, values, and skills necessary for the practice of general internal medicine or general pediatrics. The program includes a communication skills course and monthly videotape feedback of residents' interactions with their patients. Some of the areas covered in the month-long course include verbal and nonverbal behavior, stressful situations, difficult patients, therapeutic interviews, and communication of the management plan. The course uses films, readings, discussions, practice, and videotapes. These videotapes cover: (1) developing a warm physician-patient relationship, (2) formulating a holistic view of the patient, and (3) implementing effective patient education practices. Residents have responded positively to the program.

81-0365
A Hypertension Diet Education Program for Public Health Nurses.
Kostas, G.
Journal of the American Dietetic Association 77(5):570-574, November 1980.

The Hypertension Diet Education Program was a pilot program to prepare practical nurses to provide nutritional counseling to high-risk hypertensive minority group members residing in public housing in New Orleans. The program consisted of a 6-month nutrition education program for 16 nurses, and a 1-day nutrition education workshop for 25 members of the target population. The 6-month program was evaluated by pre- and postprogram tests consisting of 25 nutrition-knowledge items and 9 teaching-method items. The nurses subjectively evaluated each session and the overall program, and completed pre- and postprogram self-achievement ratings. To determine the teaching effectiveness of the subsequent workshops, pre- and posttests were administered orally to the participants. Patient records were reviewed after 8 months of dietary counseling to assess those who obtained blood pressure control by diet alone and those who were uncontrolled on antihypertensive medications but who achieved blood pressure control with dietary support. Results of evaluative data analysis indicated that the nurses' knowledge and skills were improved, and that the patients' knowledge and ability (and the ability of the minority community at large) to control their blood pressure through dietary means increased. 19 references. See also 81-0366.

81-0366
Evaluation and Follow-Up of a Hypertension Diet Education Program.
Kostas, G.
Journal of the American Dietetic Association 77(5):574-576, November 1980.

The Hypertension Diet Education Program, which was aimed at nurses working with hypertensive residents of public housing projects in New Orleans, was evaluated through a questionnaire survey of 12 nurses who participated in the program. The sample population included six nurses who had participated in the program during its 2-year history and six nurses who had participated for 12-18 months. One questionnaire sent to the nurses was used to assess the value of the teaching material, including a manual with seven lesson plans, while the other questionnaire measured the nurses' retention of nutrition information and their use of recommended teaching methods and materials. Responses indicated that all of the nurses were confident of their knowledge of nutrition and their

counseling ability; most nurses followed the lesson plans provided during the training program; most adapted the lesson plans to the individual patients; most found sample menus to be the best learning tools; all thought the material could be improved by emphasizing ethnic foods; most had retained and improved upon knowledge received during the training program; and most of their counseling methods remained the same over the 2-year period. 1 reference. See also 81-0365.

81-0367
Integration of Behavioural Science in the Preparation and Practice of Health Education in Indonesia.
Ross, H. S.; Poerbonegoro, S.; and Soetjahja, I.
International Journal of Health Education (Geneva) 23(2, Suppl.):15-22, April-June 1980.

To reduce or eliminate problems of overpopulation, communicable diseases, malnutrition, unsanitary environments, and urban poverty in Indonesia, the University of Indonesia School of Public Health has developed an academic program to equip students with culturally adapted knowledge, attitudes, and behavioral science skills. Three curricula were developed to meet the needs of health educators, i.e., undergraduates in public health, graduates in public health, and master's degree candidates specializing in health education. To facilitate program implementation, a faculty training series was conducted to improve communication among faculty members, to utilize the group dynamics process and organizational development technology to identify and resolve staff relationship problems, and to recognize and utilize effectively different leadership and membership styles. Ninety percent of participants indicated that they had learned a significant amount from the sessions. The use of behavioral science in curriculum formation is discussed in terms of cultural pluralism and teamwork, learning determinants, and cultural factors affecting applied behavioral sciences. Conclusions drawn from program implementation are provided. 18 references.

81P-0368
Men's Awareness Leadership Education (MALE).
Ward, R.
Midwest Health Center for Women, 825 South 8th Street, Suite 902, Minneapolis, MN 55404
Continuing.

The Men's Awareness Leadership Education (MALE) project of Minneapolis is designed to increase awareness of male sex-role stereotyping. The project is administered by a private, nonprofit organization. Designed for professionals working with adolescent males, the eight-session inservice training curriculum covers male stereotypes and role models, fear of intimacy among men, aggressive behavior and substance abuse, friendship and support systems, male sexuality and sensuality, emotional awareness, preparation for fatherhood, and male empathy. The group sessions, which are codirected by male and female facilitators, involve a 90-minute presentation followed by a discussion period. A film entitled "Men's Lives" accompanies the session on male stereotyping. The program is directed by an associate professor of education and sociology.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-0369
Thinking Positive About PPIs (Editorial).
Zellmer, W. A.
American Journal of Hospital Pharmacy 37(11):1487, November 1980.

The patient package insert (PPI) regulations of the Food and Drug Administration (FDA) balance the interests of consumers and the concerns of health professionals. During the year between the initial proposal and the passage of the regulations, the FDA considered 1,500 comments from interested parties. The use of "generic" PPI's will enable pharmacists to use only 10 different leaflets to cover about 300 products. The PPI regulation also allows hospitals to dispense with the PPI in cases in which its use would hinder administration of the first dose of a drug to an inpatient. The American Society of Hospital Physicians (ASHP) plans to publish a PPI compendium designed for inpatient access at nursing stations. In the future, more pharmacists should take time to discuss PPI's with patients and should gain confidence in discussing medications with patients. More consumers should read the PPI's and ask for relevant information whenever they purchase prescription medications. Counseling by physicians and pharmacists about prescription medications could become so effective that the FDA might decide that PPI's are no longer required. This position would be consistent with the position of the ASHP.

81P-0370
Prevention and Wellness Program.
Zvara, J. A.
Wisconsin Department of Health and Social Services, Division of Policy and Budget, 1 West Wilson Street,

Madison, WI 53702
1978 - Continuing.

The Prevention and Wellness Program attempts to promote and sustain the health of Wisconsin residents and to focus energy and resources on preventing physical, mental, and social ills and disabilities. Though no direct services are offered to the public, the program provides assessment and coordination services to individual projects and allocates grants. The program has administered a $980,000 State grant for funding local demonstration projects; 29 were selected for funding. These projects are designed to encourage a wide range of innovative approaches to wellness, including health and physical fitness activities, good nutrition, preventive health care, safer work environments, and family stabilization. The 37-member Prevention and Wellness Commission, which is the central body of the program, was established to advise the department and participate in planning a 4-year statewide wellness program. Each grant project is expected to produce its own process evaluation through quarterly reports and through a process summary and outcome evaluation in the final report. A performance assessment of the grant program as a whole is expected in the fall of 1981. State general-purpose revenue supports both the grant program and the administrative staff.

RESEARCH AND EVALUATION

81-0371
Pilot Study to Measure the Change in Dental Health Behaviour of Children Given Oral Hygiene Instruction in Groups of Different Sizes.
Earnshaw, L. M.; Gelbier, S.; and Plamping, D.
Royal Society of Health Journal (London) 100(2):62-63, 66, April 1980.

To determine the most cost-effective oral hygiene instruction (OHi) model, a group composed of twenty-six 11- to 12-year-old London schoolchildren was randomly divided into test and control series, with each series containing three groups and each group containing one, four, or eight children. A second group was similarly divided. To alleviate the complicating factor of peer communication within the classrooms, students in a third classroom were used as an extra control group. An oral hygiene index was assessed for all children, after which control-group children were provided with toothbrushes and toothpaste and told to brush their teeth. Children in the test groups were told about plaque and given toothbrushing instruction. After the children brushed their teeth an examiner checked the results with the children looking on in a hand-held mirror. Further instruction was provided, and the children brushed until all plaque was removed. All children were reexamined 2 weeks later. A substantial decrease in dental plaque was noted among test groups; control groups exhibited some improvement, but less than the test group. Results do not support the assumption that individual instruction is the most effective method of teaching plaque removal and underscore the need for an extended school-based educational campaign involving teachers and parents.

81-0372
Can We Measure Impact of Communication Information in Terms of Reduced Incidence of Dental Disease? (Editorial)
Horowitz, H.
Journal of Public Health Dentistry 38(2):131-135, Spring 1978.

The American Dental Association, with the cooperation of the National Institute of Dental Research, sponsored a 2-day conference on "Attitudinal and Behavioral Research in Dentistry." One segment of the conference was directed to the question, "Can we measure impact of communication information in terms of reduced incidence of dental disease?" Ultimately, attempts to change attitudes and behavior must be measured in terms of their impact on health. Some dental health literature gives the impression that disease is the lack of knowledge, proper attitudes, or desirable practice or behavior rather than the presence of an actual disease state. Toothbrushing alone does not guarantee that plaque is being removed from the teeth or that the periodontal tissues are healthy. Thus, measuring only behavior can lead to unjustified conclusions. The inspection of plaque removal is one area in which better indices for evaluating oral hygiene are needed. The possession of appropriate knowledge is only one of several factors that may lead to improved oral health and is probably not the dependent variable that should be measured.

81-0373
Evaluation of Patient Medication Counseling Sources.
Knodel, L. C. and Amerson, A. B.
American Journal of Hospital Pharmacy 37(11):1509-1513, November 1980.

Seven sources of information on patient medication counseling were evaluated by pharmacists attending five con-

tinuing education seminars. Fifty percent of the pharmacists thought the most important categories of information for inclusion in a medication counseling procedure are the intended use or expected action of the drug, directions for preparation, directions for administration, precautions, and side effects. Each source of information was reviewed to determine whether it included these five types of information for 20 drugs selected randomly from the top 200 prescription drugs. The American Society of Hospital Pharmacists' "Medication Teaching Manual" included the largest number of sample drugs; Apelgren and Rowles' "Handbook for Counseling Patients on Their Medications," Griffith's "Drug Information for Patients," Maudlin and Young's "Drug Consultation Guide," and Smith's "Medication Guide for Patient Counseling" were almost as complete. In terms of including information in each of the five categories for the sample drugs, the "U.S. Pharmacopeia Dispensing Information" and the "Medication Teaching Manual" ranked highest. All the publications are at least adequate patient counseling sources, although some are more complete than others. 6 references.

81-0374
Childhood Prevention of Atherosclerosis and Hypertension.
Lauer, R. M. and Shekelle, R. B., eds.
New York, Raven Press, 484 p., 1980.

Evidence related to the origins of atherosclerosis and hypertension is reviewed, and research that may result in childhood prevention strategies is discussed. Topics include lifestyle interventions as a means of primary prevention during childhood; the pathogenesis of atherosclerosis; the role of plasma lipids, body fat, cigarette smoking, and blood pressure in the etiology of atherosclerosis and hypertension; intervention strategies; and health considerations for the workplace. Numerous references.

81-0375
A Summary of a Survey of HMO Health Education Programs in the United States.
Metropolitan Life Insurance Company, New York, N.Y. Health and Safety Education Div.
(New York), Metropolitan Life Insurance Company, 14 p., 1980.

A questionnaire survey undertaken in 1979 of 175 health maintenance organizations (HMO's) assessed the level of health education activities directed to HMO members. Of the 96 respondents, 94.7 percent have developed some form of educational program that addresses wellness, health promotion, and prevention. Types of educational material used, in order of frequency, included brochures, newsletters, filmstrips, films, slides, tapes, and workbooks. Educational materials addressing appropriate use of services were developed internally by 71.1 percent of the HMO's, while 26.5 percent used supplementary help at least occasionally. Materials addressing wellness, prevention, and health promotion were developed in cooperation with an outside agency or organization in 82.2 percent of cases. Materials for acute and chronic disease programs were developed in cooperation with an outside agency in 60.6 percent of the cases. Most HMO's (66.3 percent) had only one employee or no employee concerned solely with the educational interests of HMO members. Finally, although 50 percent did not engage in any attempt to evaluate the effectiveness of their educational programs, 90 percent indicated a need for help in developing an educational strategy. A list of the HMO's contacted is appended. 85 references.

81-0376
Hammaslaaketieteellisten Terveyskasvatusohjelehtisten Luettavuus (Readability of Dental Health Education Material).
Murtomaa, H.
Proceedings of the Finnish Dental Society (Helsinki) 75(4):72-74, 1979.
(Finnish).

The readability of 10 dental health education booklets published by the Finnish Dental Society was analyzed using a "reading ease formula" for use in evaluation of Finnish publications. The formula takes into account word length as well as proportions of adjectives plus adverbs, and nouns plus verbs. A characteristics profile was also developed for each text. The reading levels of six booklets were above that of the average Finn, who reads at a seventh grade level. The characteristics profile indicated that five booklets were difficult in comparison with normal Finnish usage. 7 references.

81-0377
Health Education: Attitudes and Evaluation.
Nicklin, L.
Nursing Times (London) 73(25):7-8, 11, June 23, 1977.

In implementing an evaluation component for a hospital health education program, the designer should thoroughly understand the desired objectives; target audiences; results of similar campaigns; and political, social, and economic constraints on the involved health team. The component designer also should be aware of epidemio-

logical data on ailments related to lifestyle risk factors. Since, in a sense, all health education efforts can be seen as part of a single campaign, it is dangerous to attribute improved health statistics to any particular program. Instead, cumulative effects should be considered. With this qualification, it appears that the successive campaigns mounted by the British Health Education Council in 1974, 1975, and 1976 have reduced the level of smoking among the target populations. To maintain the effect produced by these campaigns, vigorous reinforcement by health professionals is necessary. Finally, an understanding of the effect of audience participation, the reactions of various social groups, and the importance of feedback mechanisms is vital to the efficacy of any program. 1 reference.

81-0378
Cardiovascular Disease and Diet: Research Findings for Classroom Use.
Roush, R. E.
Health Education 11(5):23-27 September-October 1980.

An overview of reported studies describing cardiovascular disease (CVD) and atherosclerosis, the relationship of diet to CVD, and selected trials designed to lower lipid concentrations in the blood is presented. Studies conducted among rural Africans who move to urban areas and among persons eating a traditional Japanese diet indicate that diets low in fiber and high in saturated fat and cholesterol contribute to CVD. Similarly, several studies conducted since 1951 have indicated that high levels of high-density lipoproteins, in contrast to those of lower density, protect against atherosclerotic heart disease. Many factors have influenced the recent decline of CVD among males in the United States, particularly diet. Although experiments like the Tecumseh Study show that serum cholesterol and triglyceride levels are not correlated with dietary intake, several other studies, involving varying age groups and with experimental durations of up to 7 years, indicate a close correlation between dietary intake, levels of serum cholesterol, and incidence of CVD. Three studies on the effects of educational programs on diet are appended. 34 references.

81-0379
Suffolk Health Information Profile; Results--1979.
Suffolk County Dept. of Health Services, Hauppage, N. Y. Office of Health Education and Public Information.
(Hauppage, N. Y.), the Department, 46 p., (1979?).

The Suffolk Health Information Profile (SHIP) is a 110-question instrument with two parts: (1) a knowledge test on sex, drugs, nutrition, first aid and safety, and smoking; and (2) an attitude and behavior survey on physical health, mental health, smoking, nutrition and diet, exercise, drugs, and traffic safety. SHIP was developed on an experimental pretest basis and administered to 1,872 incoming freshmen at Suffolk Community College in Lake Ronkonkoma, New York, in 1979. A detailed review of the knowledge test and an analysis of the behavior survey are included.

RISK REDUCTION

81-0380
Cultural Barriers to Preventive Dentistry.
Blaikie, D. C.
Australian Dental Journal (Sydney) 24(6):398-401, December 1979.

Dental attitudes and behavioral characteristics of lower socioeconomic groups are examined in relation to the premise that desirable dental attitudes and habits are inconsistent with the cultural values of these groups. Aspects of lower level socioeconomic groups that may influence dental care include (1) a definition of health which defines ill health in terms of incapacitation or inability to fulfill daily requirements; (2) barriers to intimate social participation with other groups, which foster ignorance of health-related matters; (3) a fatalistic philosophy; (4) an orientation to the present that is centered around gratification of basic needs; (5) a preference for personal relationships, coupled with a view that formal situations, particularly bureaucratic situations, are cold and belittling; and (6) a reliance on authority, which affects family relations, child-rearing patterns, and attitudes toward community institutions. Implications of these postulations for preventive dentistry are discussed.

81-0381
Perspectives on Health Promotion and Disease Prevention. The Health Policy Council Task Force Paper, July 1980.
Canton, J. M., et al.
Des Plaines, Ill., Health Policy Council, 16 p., 1980.

The conclusions derived from eight Regional Forums on Community Health Promotion, held between February and September, 1979, are reported. The purpose of the forums was to promote local awareness and action for health improvement through risk reduction; health education; and positive enhancement of services, the environ-

ment, and lifestyles. Topics include the impressions of participants about local attitudes concerning health promotion, contrasts between "sickness care" and "health care," questions and responses on health promotion and disease prevention, and conclusions and implications for health policy. 17 references.

81-0382
Changing Cardiovascular Risk Factors in Entire Communities: The Stanford Three-Community Project.
Farquhar, J. W.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 435-440, 1980.

The Stanford Heart Disease Prevention Program Three-Community Project, implemented in three similar communities in northern California, used a family-community model rather than a medical center model to alter cardiovascular risk factors of community members. The project involved symmetrical mass media campaigns in 2 of the communities over a 3-year period, including 50 television spots, 3 hours of television programming, weekly newspaper columns, newspaper stories, billboards, posters, and mailings. The third community served as a control group. In one of the two experimental communities, a group of high-risk individuals and their spouses were given intensive supplemental instruction through personal contact. Annual surveys of attitudes; knowledge of risk factors; and diet, smoking, and exercise behavior were obtained from a random (multistage probability) sample of men and women 35-59 years old. In addition, measurements of cholesterol, triglyceride, body weight, and sodium-potassium ratios were obtained, and estimated risks of future coronary heart disease were obtained from a multiple logistic equation. Analysis of evaluation results indicated that base-line values were similar for all communities; the campaign was successful in positively altering knowledge and risk factor variables; counseling significantly reduced weight among the high-risk group members; and the results remained relatively unchanged after 3 years. 21 references.

81-0383
The Secret Behind Smokenders.
Frumkes, L. B.
Family Health 12(6):16-18, 29, 1980.

"Smokenders," a smoking cessation seminar based on personal motivation and use of substitute activities, is investigated. Initially, participants learn new concepts and review misconceptions about smoking, which are written in a log book. Participants are then asked to wrap an adhesive-backed chart around their cigarette pack and to note on it the time of each cigarette smoked; they are also asked to switch to another brand, discard cigarette paraphernalia, change the side of the mouth used to smoke, and deposit a week's worth of cigarette butts in a jar of water. Next, smokers learn the complexities of the smoking habit. All instructors are ex-smokers who do not threaten smokers with portents of death or disease, but slowly and carefully help the smoker detoxify, reinforcing confidence with each step. After the fifth session, smokers are asked to have one last cigarette and then to quit; by this point they should be ready. To date, over 200,000 people have quit smoking through the program.

81-0384
Seize the Moment: Health Promotion for the Young Adult.
Johnson-Saylor, M. T.
Topics in Clinical Nursing 2(2):9-19, July 1980.

An approach to adolescent health promotion, based on three goals, is presented: (1) health maintenance based on risk and geared toward disease prevention; (2) early detection; and (3) attainment by the client of wholeness, balance, and optimum functioning capabilities. The framework of the approach addresses (1) the issues of lifestyle, developmental stages, and health-care cost perception; (2) a planned intervention that builds on the strengths the client already possesses regarding health; (3) assessment of patient behaviors and risk factors, inquiry about lifestyle changes, personal development assessment, and awareness of patient perceptions of health and illness; and (4) the intervention itself, in which areas of concern are mutually identified; avoidable risk factors are presented; moderation in alcohol consumption and smoking cessation is emphasized; family histories are considered; stress management methods are presented; the importance of good nutrition is noted and dietary deficiencies treated; the value of exercise is reviewed; values-clarification exercises concerning sexuality are undertaken; difficulties in accomplishing developmental tasks are discussed; early cancer detection methods are taught; and resulting changes in behavior are evaluated. 24 references.

81-0385
Prevention of Fetal Alcohol Syndrome: A Model Program.
Little, R. E.; Streissguth, A. P.; and Guzinski, G. M.
Alcoholism: Clinical and Experimental Research 4(2):185-189, April 1980.

The Pregnancy and Health Program, established in 1978 in King County, Washington, by the University of Washington, is designed to prevent fetal alcohol syndrome. The program involves raising community awareness through a public education and professional training effort, providing direct client services to mothers and children and revising and evaluating program activities. The community awareness component includes a media campaign using television, radio, and newspapers; a brochure distributed at places frequented by pregnant women; a 24-hour hotline; and a screening network in prenatal clinics. Similarly, professional training is directed at physicians, educators, nurses, and other health professionals who frequently come into contact with pregnant women. Client services include obstetrical and detoxification services, individual and group counseling, referral to community alcoholism programs and practitioners, home visitation by nurse practitioners, and screening of women and their children. Base-line surveys were conducted before the program began and will be repeated in 1981. Problems encountered by the program include reluctance on the part of alcoholic women to seek services, addiction to detoxification drugs among some clients, lack of day care services for clients' children, uncooperative physicians who may try to protect clients from the service, and negative public reaction to the media campaign.

81-0386
Health Education and Risk Assessment: A New Role for Physicians in Primary Prevention.
Morgan, P. P.
Canadian Medical Association Journal (Ottawa) 120(6):623-626, March 22, 1980.

Several constraints that deter physicians from emphasizing primary prevention are outlined: (1) the lack of time, (2) the unwillingness of third-party payers to acknowledge the time or training the practitioner must invest in primary prevention, (3) the failure of physicians to adopt and develop new skills and attitudes, and (4) the lack of immediate rewards for at-risk patients. However, an emerging public attitude toward health demands that physicians play a leading role in primary prevention. The need for medical school departments of preventive medicine to develop risk-assessment curricula is examined, and the benefits of risk-assessment utilization by primary care physicians are discussed in terms of the doctor-patient relationship. 15 references.

81-0387
An Exercise "Prescription" for the Sedentary Executive.
Moudry, G. J.
Occupational Health and Safety 49(4):29-32, 53, April 1980.

The Athletic Center of Atlanta was developed to achieve improvements among sedentary executives in all aspects of physical fitness, including cardiovascular and muscular endurance, strength and flexibility. A typical exercise session consists of a 5- to 8-minute warmup before running 2 miles on an indoor track. Most participants start with a walking-jogging combination, gradually increasing the jogging. After 2 miles, participants are trained for strength and flexibility on Nautilus machines. After strength training, the participant jogs another mile and goes to the showers only after heart rate drops to 110. Participants are encouraged to attend three times weekly. Results of an evaluation showed significant improvements in cardiovascular function for both men and women, lower resting heart rate and diastolic blood pressure, and increased maximal oxygen consumption. Strength was increased dramatically and body weight was reduced. Participants experienced the greatest improvements in physical fitness following 30 weeks of regular exercise, after which they reached a plateau in most parameters. Lower fitness-level participants demonstrated the greatest improvement. Class attendance, exercise adherence, injury recognition and treatment, and attrition rate are discussed. 8 references.

81-0388
Clearing the Air: A Guide to Quitting Smoking.
National Cancer Inst. (DHHS, NIH), Bethesda, Md. Office of Cancer Communications.
Bethesda, Md., the Institute, 36 p., March 1980.

Advice on how to quit smoking is provided. Methods include gradually reducing the number of cigarettes smoked, in anticipation of the planned quitting date; avoiding situations that habitually involve smoking; planning alternative activities; and planning ahead to avoid weight gain (which occurs in only about one-third of cases). Seeking professional help and utilizing formal programs are also discussed.

81-0389
Living Well: An Introduction to Health Promotion and Disease Prevention--From the Surgeon General's Report on Health Promotion and Disease Prevention.
Office of Health Information, Health Promotion and Physical Fitness and Sports Medicine (DHEW, PHS), Washington, D.C.
Washington, D.C., the Office. DHEW (PHS) Publication No. 80-50121, 35 p., (1980).
Available from: GPO; Stock No. 017-001-00416-2.

Guidelines for lifestyle risk reduction are offered. It is estimated that, in the United States, 350,000 deaths per year can be linked to cigarette smoking, 100,000 to accidents, and 200,000 to misuse of alcohol. Goals established by the Department of Health, Education, and Welfare for 1990 include reduction of infant mortality by 35 percent, reduction of deaths among children 1-4 years old by 20 percent, reduction of deaths among persons 15-24 years old by 20 percent, reduction of deaths among persons 25-64 years old by 25 percent, and reduction of the number of days of restricted activity due to acute and chronic conditions by 20 percent. To aid in Government efforts to reach these goals, the individual should eat sensibly, exercise regularly, avoid any type of addiction, be safety conscious, and learn to handle stress.

81-0390
Changing the Cardiovascular Risk in an Entire Community: The North Karelia Project.
Puska, P.; Tuomilehto, J.; Nissinen, A.; Salonen, J.; Maki, J.; and Pallonen, U.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 441-451, 1980.

The North Karelia Project was initiated in 1972 to lower the risk of cardiovascular disease in the rural community of North Karelia, Finland. A base-line survey of a representative sample of 12,500 persons 25-59 years old indicated that 54 percent of the adult males were smokers and that their cholesterol levels and blood pressure were generally high. The community program that evolved provided general information to the public, individual services, environmental change strategies, personnel-training services, and information services to support implementation of the program. Methods employed in the effort included newspaper notices, radio spots, posters and stickers, meetings, public campaigns, school programs, worksite programs, special supportive services, services by other organizations, public-smoking restrictions, promotion of low-fat dairy products and sausage, promotion of vegetable cultivation, and use of various documentation and followup evaluation techniques. Followup surveys have indicated that smoking among males has been reduced by 11 percent, more than 8,500 hypertensives have become aware of their condition through project efforts, the number of controlled hypertensives has risen significantly, serum cholesterol levels among males in the province have decreased significantly, and the incidence of cardiovascular disease has declined. The program and its evaluative components will continue after the initial 5-year period.

81-0391
You Can Stop: A SmokEnder Approach to Quitting Smoking and Sticking to It.
Rogers, J.
New York, Simon and Schuster, 187 p., 1977.

Practical guidelines are provided for implementing a smoking cessation program using the "smokEnder" method. Topics include understanding motivations for smoking, identifying alternatives to smoking, learning means to cope with the anxieties of cessation, dealing with cigarette advertising, changing other habits, dealing with smokers, understanding the rights of smokers and nonsmokers, implementing cessation practices, understanding the benefits of quitting, and understanding the fundamentals of addiction.

81-0392
Improved Life Styles: Their Potential for the Primary Prevention of Atherosclerosis and Hypertension in Childhood.
Stamler, J.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 3-36, 1980.

An overview of published research and other literature on the relationship between modern Western lifestyles and the development of atherosclerotic disease and hypertension suggests the potential for reducing the risk of coronary heart disease by means of primary prevention interventions aimed at children. The accumulated data underscore the key role of lifestyle--particularly diet, cigarette smoking, sedentary habits, and the hectic behavior patterns stimulated by a competitive society--as well as lifestyle-related traits, particularly hypercholesterolemia and hypertension. These data come from analyses of International Food and Agriculture Organization and World Health Organization studies, international autopsy studies, international studies of living populations, epidemiological studies in the United States, and metabolic ward and experimental animal studies. In the United States, mortality rates from coronary disease have been declining steadily since 1968. Though it is impossible to definitively link the recent changes in lifestyle to these decreases in mortality rates, it certainly is possible that the two trends are related. 112 references.

81-0393
The Role of Visual Feedback by a Disclosing Agent in Plaque Control.
Tan, A. E. S. and Wade, A. B.
Journal of Clinical Periodontology (Copenhagen) 7(2):140-148, April 1980.

The prescription of disclosing agents for home use assumes a relationship between visual feedback from stained plaque and subsequent oral hygiene behavior. A double crossover study revealed no significant difference between a group that received only individual oral hygiene education and a group which had the same hygienic education supplemented by the use of a disclosing agent for 2 weeks. On receiving oral hygiene reinforcement and discontinuing disclosing-agent use, the latter group showed further significant improvement in plaque control after another 2 weeks. Findings suggest that visual feedback from the disclosing agent did not motivate patients; therefore, a disclosing-agent prescription should not be considered mandatory. Thorough and repeated oral hygiene education remains the most important feature in patient motivation. 22 references.

81-0394
Raising a Smoke-Free Generation in Sweden.
Tibblin, G.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 453-458, 1980.

In response to increased levels of smoking among the population of Sweden, the Tobacco Commission, appointed by the Board of Health and Welfare in December 1971, formulated a number of policy actions to curtail smoking nationwide. The goals developed by the commission include reducing cigarette consumption to 1920's levels, prohibiting consumption of other tobacco products, and promoting a negative social attitude towards smoking. During the interim period prior to the attainment of the main goals, the committee declared that children should grow up in an antismoking environment, that certain key groups who affect the development of children should stop smoking, and that market regulations should support the rest of the program. The board declared that all tobacco packaging should carry health warnings that list tar, nicotine, and carbon monoxide content; these warnings are reviewed every other year. Other activities sponsored by the committee include preschool and school education programs, mother and child care programs, workplace programs, and public distribution of antismoking booklets. Since the inception of the program, rates of smoking cessation among males and females have increased significantly. In the future, the commission hopes to restrict the advertisement of tobacco products in the print media. 1 reference.

81P-0395
Bayview-Hunters Point Community Hypertension Project.
Williams, R.
Ambulatory Health Care Facility Corporation, 2401 Keith Street, San Francisco, CA 94124
Funding Source: California State Dept. of Health Services, Sacramento.
October 1978 - Continuing.

The Bayview-Hunters Point (California) Community Hypertension Project was initiated to improve adherence to medical regimens by improving the patient-provider relationship. Project services include outreach home visits; screening at schools, churches, and facilities for the elderly; patient education classes; and media campaigns. The target community consists of 50,000 people in the Bayview-Hunters Point area. Hypertensive patients are referred to the appropriate facilities. Screening and education campaigns are evaluated by checking the blood pressure of identified hypertensives each week for the first month after screening. A 10-minute appointment with the treating physician is also scheduled each week for 4 weeks.

81P-0396
Child Passenger Safety Resource Center.
Zyb-Wisensale, N.
Massachusetts Department of Public Health, Division of Preventive Medicine, 600 Washington Street, Boston, MA 02111
Funding Source: Dept. of Transportation, Washington, D.C.,
May 1980 - Continuing.

The Child Passenger Safety Resource Center was established to reduce automobile passenger deaths and injuries among children under 17 years of age in Massachusetts. The center promotes, through the visual and print media, the need for child safety seats and restraints; provides inservice education programs for health professionals; and provides community outreach and education on child automobile safety. Methods for evaluating center effectiveness include the use of morbidity and mortality data from the Massachusetts Registry of Motor Vehicles and from hospital reporting services. In addition, student volunteers involved in research methods courses will conduct annual observation surveys, during which they will observe the use of restraint devices at key traffic points during specific times. The center will also participate in a statewide telephone survey to provide base-line attitudinal data, from which changes can be measured over a 3-year period. Additional evaluation methods include an

annual review of the percentage and location of the target population requesting center materials, and a review of data on sales of automobile safety seats and restraints.

81P-0397
Everyone Can Do Something About Smoking.
American Lung Association, 1740 Broadway, New York, NY 10019
Fall 1978 - Continuing.

"Everyone Can Do Something About Smoking" enables physicians to take an active role in discouraging smoking. The physicians speak to community groups and use an accompanying kit that contains a slide-tape program and two leaflets for each participant. A discussion period follows the slide-tape presentation. Specific suggestions are offered for people who want to become involved in establishing smoking cessation programs in the workplace, schools, or other public places. The package provides information on existing smoking education programs for youth, the status of smoking legislation, and available smoking cessation programs. The program depends upon local promotion by family practice physicians, American Lung Association staff, and volunteers. During a year-long period beginning in the fall of 1978, more than 150 lung associations ordered over 250 kits. The program was created and is promoted through the cooperation of the National Cancer Institute, the American Academy of Family Practice, and the American Lung Association.

81P-0398
Good Health Program.
Zeigler, D. W.
Skokie Valley Community Hospital, 9600 Gross Point Road, Skokie, IL 60076
Continuing.

Skokie Valley (Illinois) Community Hospital's Good Health Program educates and motivates target populations to change high-risk personal habits voluntarily. The program offers screening and followup intervention programs to deal with health risk factors and provides referral services. Intervention programs include a 6-day smoking cessation clinic; a 6-session nutrition education course; a 5-session stress management course; a 4-session exercise and physical fitness course; a 14-session weight control course; and several optional courses in these areas as well as in self-examinations, alcohol use and abuse, and defensive driving. The screening procedure includes use of a version of the health hazard appraisal questionnaire and measurements of height, weight, frame, skinfold, blood pressure, cholesterol level, pulse recovery, carbon monoxide level, urine sugar, hemoccult (which tests for blood in the stool), and glaucoma symptoms. Individual counseling on the basis of data analysis is provided after screening. Classroom activities involve lectures, group discussions, panel discussions, film presentations, behavior modification techniques, and demonstrations. Though the entire community served by the hospital is encouraged to participate in the programs, specific efforts are made to convince employers, labor leaders, community organizations, schools, and hospital patients to implement such programs.

81P-0399
How to Quit Smoking On Your Own--A Two Session Smoking Cessation Program.
Morrissette, B.
Massachusetts Department of Public Health, Division of Preventive Medicine, 600 Washington Street, Boston, MA 02111
December 1978 - Continuing.

The "How to Quit Smoking On Your Own" smoking cessation program has been implemented to determine whether a two-session, 5-hour smoking cessation program can achieve cessation rates similar to those of longer programs. Methods include habit awareness techniques, rewards for success, and alternative behaviors to smoking. In the 16 months between December 1978 and March 1980, 10 groups totaling 190 people participated in the program. Eight programs were conducted by the program developer and a trainee and two programs by newly trained leaders. The program director holds a master's degree in public health. Preliminary data indicate that the 1-year cessation rates are similar to those achieved in longer programs, i.e., 20 to 30 percent. Due to minimum staff time necessary to implement the program and the fact that laypeople can be easily trained as session leaders, the program can be administered at a low cost.

81P-0400
Northern Michigan University Alcohol Education Program.
Shaffer, G. P.
Northern Michigan University, University Center, Marquette, MI 49855
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.; Michigan State Dept. of Public Health, Lansing. Michigan Office of Substance Abuse Services; Northern Michigan Univ., Marquette.
October 1978 - Continuing.

The Alcohol Education Program for the faculty, staff, and 8,000 students of Northern Michigan University is designed to promote responsible decision making among students about alcohol use. Services include workshops and classroom presentations on alcohol-related topics, workshops on general student development topics, production of media campaigns, training for student service providers, dissemination of materials to faculty members, assistance for students doing research on alcohol-related topics, and referral. The program is in frequent contact with other college-based programs throughout the country. Evaluation methods include general feedback, an annual alcohol survey of 1,000 students, and special research projects to determine the impact of various approaches.

SCHOOL HEALTH EDUCATION

81-0401
Cancer Education in Schools (Editorial).
South African Cancer Bulletin (Johannesburg) 21(2):45-46, April-June 1977.

Alarmed by the rapid rise in cigarette smoking among youths worldwide, the International Union Against Cancer has launched a program to promote school-based education about the hazards of cigarette smoking and cancer. Experts from six countries brought together medical practitioners, health educators, teachers, educational authorities, and curriculum developers to draw up sample lessons for incorporation into school curricula. Lesson plans explain the nature of cancer, its causes, detection, and treatment, and serve to prevent children from developing the fear of cancer that often stops adults from obtaining early diagnosis and treatment. The group will produce a teacher's guide for cancer education for educators throughout the world.

81-0402
Health Education: A Planning Resource for Wisconsin Schools.
Bradley, C. E. and Sanders, L., eds.
Madison, Wisconsin Department of Public Instruction, Division for Instructional Services, Pupil Services Section (Bulletin No. 9020), 155 p., 1977.
Available from: ERIC; Order No. ED-162 239.

Guidelines for developing a health education curriculum for students in grades K-12 are presented for use by district health education coordinators and other instructional leaders. Part I offers a practical curriculum-planning process. Part II identifies broad health competencies in four major content areas: mental health, physical health, safety, and community health education. The competency objectives are consistent with and support "Wisconsin's Goals for Elementary and Secondary Education," adopted by the State superintendent of schools upon the recommendation of a task force. Part III includes references as well as appendices of State statutes and supporting statements about health education.

81-0403
Adolescent Homosexual Behavior and the Health Educator.
Chng, C. L.
Journal of School Health 50(9):517-521, November 1980.

Health educators should help all students develop an understanding of homosexuality and a tolerance toward different sexual lifestyles. Social repression of sexuality during adolescence can lead to transient homosexual periods for some youths. The health educator should act as an instructor, a source of referral, and an agent of change. The educator can encourage tolerance among students by helping them realize that human sexuality is a continuum and that a brief period of homosexual activity does not indicate that an individual is a homosexual. Inviting homosexuals to participate in forums with students can also contribute to the humanization of homosexuality. The educator must occasionally refer a homosexual student to counseling resources within the community. In dealing with issues related to homosexuality, the educator should teach by example and strive to minimize homosexual stereotyping. 20 references.

81-0404
Editorial: Promoting High Level Wellness in a University Student Population.
Duncan, D. F.
Health Values: Achieving High Level Wellness 4(5):207, September-October 1980.

The Student Wellness Resource Center at Southern Illinois University at Carbondale is an adjunct to the wellness promotion courses offered in the university's general studies program. Over the past 2 years, the center has emphasized wellness activities that are broader than the normal wellness curricula offered by many universities and colleges. 7 references. See also 81-0405 and 81-0433.

81-0405
Bottoms Up: An Alcohol Abuse Prevention Model for College Campuses.
Eckert, P. S.
Health Values: Achieving High Level Wellness, 4(5):222-228, September-October 1980.

The Alcohol Education Project (AEP) at Southern Illinois University at Carbondale is a replication of a college alcohol-abuse prevention model initiated by the National Institute on Alcohol Abuse and Alcoholism. The AEP, which has been funded for 3 years at $100,000 per year, is staffed by one full-time project director with a school and public health background, one full-time education specialist, one half-time alcohol education specialist, four peer educators, one graduate assistant performing evaluation tasks, one evaluation consultant, and one full-time secretary. The project's activities include needs assessment, training and use of peer educators, community development work, determination of special target populations, early identification of those experiencing problems with alcohol, information dissemination, and evaluation. The systems approach employed by AEP involves the cooperation of the student health program, student housing, the student center, the counseling center, and the alcohol services of the local community mental health center. In the area of intensive approaches, more than 100 single-session workshop groups involving over 1,900 students have met in the first 18 months of the program. AEP is evaluated through an annual survey of a random sample comprising 5 percent of the student population, an annual survey of all professional staff who deal with student problems, client feedback forms, a review of institutional records, and evaluation of residence hall programming. 7 references. See also 81-0404 and 81-0433.

81-0406
Two Programs Exemplify Nationwide Involvement in School Health Education.
Evans, N. L. and Middleton, K. H.
Health Education 19(6):42-43, November-December 1979.

The Primary Grades Health Curriculum Project (PGHCP), or Seattle Project, and the School Health Curriculum Project (SHCP), or Berkeley Project, emphasize activities designed to help students understand bodily function, factors affecting health, and principles of decision making. Project activities encompass many aspects of the students' immediate world, both academic and extracurricular, and maximum involvement of community members and school personnel is stressed. The curricula are designed for students attending grades K-7 and can be implemented in an 8- to 12-week period. Interested faculty participate in a weeklong workshop in groups of four to five. In many districts, another session is held about 9 months after training to provide a forum for teachers to share experiences. At present, these curriculum projects are being implemented in over 400 school districts in 35 States, and in England and Saudi Arabia. The U.S. Office of Education and the National Institute of Education have validated the curriculum units for grades 5-7, and validation for the K-4 grade units will be conducted soon.

81-0407
Deterring Smoking in Adolescents: A Social Psychological Perspective.
Evans, R. I.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 459-464, 1980.

A recently developed social-psychological antismoking campaign is based on the premise that students can be "nursed" through the period during which they are particularly vulnerable to social pressures to smoke. This program was conducted for a 10-week period with 750 seventh grade students in the Houston (Texas) Independent School District. The pilot program involved presentation of four 10-minute videotapes featuring adolescent actors who present smoking information and role play certain social situations in which pressure to smoke is encountered. After each videotape presentation and accompanying a discussion designed to reinforce the message in the videotape, a carefully designed poster addressing the issue of peer pressure was displayed in the classroom. Students made oral and written responses to the videotape presentations. Dependent variables assessed included smoking information, smoking attitudes, intention to smoke, reported smoking behavior, and results of a nicotine-in-saliva analysis. Students in classes experiencing program interventions were significantly less likely to begin smoking than students in control classes. A longitudinal study involving 4,500 students is underway to assess the long-term effectiveness of the interventions. 8 references.

81-0408
What Did Schoolchildren Gain From the Second National Dental Health Week?
Evian, C.; Weinberg, B.; and Cleaton-Jones, P.
Journal of the Dental Association of South Africa (Pretoria) 33(7):369-372, July 1978.

In 1974 the Dental Association of South Africa initiated a long-term health education program to increase public dental awareness. Each year a National Dental Health Week is sponsored, during which there is nationwide dissemination of dental information through schools, the mass media, and the dental and allied health professions. The second National Dental Health Week emphasized major causes of dental caries, periodontal disease, and measures to prevent them. The dental knowledge of 1,706 schoolchildren was assessed before and 6 months after the program. Results revealed a slight increase in dental knowledge and significant increases in oral hygiene (as measured by oral hygiene indices) in children examined after dental health week. A sample dental quiz is appended. 4 references.

81-0409
The Expanded Role of the School Physician.
Farley, W. J.
Journal of the Medical Society of New Jersey 76(12):821-824, November 1979.

The need for a reorientation and redefinition of the school physician's responsibilities is discussed. Topics include (1) school health services, including student health maintenance, school physical examinations, and periodic health appraisal recommendations; (2) provision of health services outside of school, particularly for poor families; and (3) the school physician's duties in athletics, participation in the child study team to identify handicapped children, and health education. 9 references.

81-0410
Der Erste Schritt; Ueber einen Erfolgreichen Versuch zur Gesundheitserziehung in der Schule (The First Step: An Effective Study of School Health Education).
Hahn, A.
Quintessenz Journal 7(10):7-12, October 1977.
(German).

Health education programs in middle schools (grades 5-8) should include a dental care program taught by a dental hygienist. One such program consists of 2 class hours, including a description of the development of dental caries and its treatment, guidelines on caring for teeth, and advice on proper nutrition as a preventive measure. Particular attention is given to discussions on the consumption of sweets. In the program, children are also taught how to brush their teeth and rinse their mouths properly. A series of pictures illustrating the toothbrushing techniques as demonstrated by the children is included.

81-0411
Nutrition and the Department of Education: To Learn to Make Food Choices Responsibly Is a Goal of Nutrition Education.
Powers, M. A.
Health Education 11(5):11-13, September-October 1980.

Nutrition programs and policies of the U.S. Department of Education suggest that educational experiences are likely to be acted upon when they address the availability, acceptability, and usability of food. Social and individual responsibility are involved in education about food and nutrition. In accordance with the policies of the Department of Education, the method by which elementary and secondary schools strengthen their nutrition education approaches is left to the discretion of State and local agencies. A variety of Federal programs have been implemented to equalize educational opportunities for educationally deprived children. Of these programs, only Head Start and Follow Through are required to include nutrition services and education. A second mission of the Department of Education is to assist local agencies in improving their practices by supporting adult and vocational education, career education, consumer homemaking, and many other programs in which nutrition is implicit. To integrate nutrition into the educational experience of a school population, the Department of Education suggests including experiential components in the educational design, screening students for dietary problems, supporting other facets of the curricula with nutrition education, and incorporating nutrition service or educational components into special projects implemented by the school.

81-0412
The Issue of School Health Education: Theory and Practice.
Stone, D. B. and Rubinson, L. G.
Public Health Reviews 8(1):45-79, January-March 1979.

The historical and philosophical development of school health education in the United States is reviewed. Early instructional efforts emphasized anatomy, physiology, physical training, and hygiene, with little attempt to integrate and apply scientific concepts from the fields of education, sociology, anthropology, and psychology. As these latter disciplines began to influence more recent efforts, health education came to be perceived as a process that increases the abilities of people to make intelligent decisions concerning their personal, familial, and communal well-being. Even more recently, several unique school programs have promoted the view that children should assume personal responsibility for the preservation of their own health. Programs with particular promise include the

School Health Curriculum Project, the Know Your Body Program, the School Health Education Study, the Health Activities Project, American Heart Association projects, the Basic Cardiac Life Support Program, and the Heart Attack Prevention Program. One of the major challenges that school health educators will face in the near future is the need to demonstrate the effectiveness of health education to the public, health professionals, and educators. Finally, health educators must take a more active political role and must learn to use the mass media more adequately. 80 references.

81-0413
The Lifestyling Program: Moving Toward High Level Wellness.
Vierke, S.
Health Values: Achieving High Level Wellness, 4(5):237-241, September-October 1980.

The Lifestyling Program, a division of the Student Wellness Center at Southern Illinois University at Carbondale, was established in August 1979 to help students shape themselves and their environment to optimize health and well-being. The program is staffed by one full-time professional health educator, two half-time graduate assistants, and practicum and internship students from a variety of disciplines, and is funded by $30,000 from student medical benefit fees. Students seeking assistance from the program are guided through a three-step process of health behavior monitoring, values clarification, and contracting for behavioral change. The program provides educational presentations; individual consultation; behavioral change groups; and single-session workshops in exercise, ecology, nutrition, and relaxation. Pamphlets and books on holistic health and wellness are also available. Also, the program sponsors special events on a periodic basis in conjunction with other university units. Process evaluations are conducted for all direct services; outcome evaluations and long-term followup studies are underway for the behavioral change groups. 4 references.

81P-0414
AL-CO-HOL.
American Automobile Association, 8111 Gatehouse Road, Falls Church, VA 22047
1978 - Continuing.

AL-CO-HOL is designed to help junior high school students avoid drunken driving and other alcohol abuse situations. The program (1) provides information about the influence of alcohol on the body and mind; (2) encourages students through games and other techniques to assess their attitudes and behavior in relation to drinking; and (3) helps students anticipate ways to cope with, or avoid, drinking situations. The course is planned for five 45-minute classroom periods, in which teams work on role playing, games, group discussions, and home assignments; each team accumulates points as the course progresses. Materials include a student handbook, a teacher's guide, a supplemental materials packet, a related film for teachers and administrators, a series of films for classroom use, and forms for pre- and posttests. In addition to test scores, performance on take-home assignments and classroom participation can be used for assigning grades and for program evaluation.

81P-0415
Family Life Education Program Development Project.
Wagman, E.
Planned Parenthood of Santa Cruz County, 212 Laurel Street, Santa Cruz, CA 95060
Funding Source: Office of Family Planning (DHHS, HSA), Washington, D.C.
July 1978 - Continuing.

The Family Life Education Program Development Project was created to test a program model for implementation within school districts. Services include implementing a minimum 10-day curriculum unit; training district personnel during a 5-day inservice workshop and a 1-day follow-up workshop; adapting tested curriculum materials to the particular needs of each district, with the aid of local curriculum advisory committees; and encouraging community involvement and support throughout the implementation process. The recently completed 400-page curriculum guide is designed to serve as a model for teachers setting up high school programs. Over 10,000 students and 150 teachers from 13 California school districts are participating in the study. The first 2 years of the project have focused on junior and senior high school students; in the third year, curricula for grades 4-6 and teacher-training components will be developed. Program activities are being evaluated by means of summative evaluation meetings and interim progress reports, student pre- and postprogram cognitive and attitudinal testing, collection of feedback data from students, pre- and postprogram cognitive and attitudinal testing of teacher trainees, collection of feedback data from the trainees and the monitoring of changes in trainee behavior, and assessment of factors that impinge upon the successful implementation of the program within a given school district.

81P-0416
I'll Never Smoke (INS).
Engel, B. E.
American Lung Association of Iowa, 1321 Walnut, Des Moines, IA 50309
Continuing.

"I'll Never Smoke" (INS) is designed to reduce the number of young people who smoke by enabling them to resist peer pressure and the pressure of tobacco industry advertising. The program develops and implements separate workshops for school faculty and for groups of interested students. The general program employs peer teaching techniques, while the workshops utilize lecture and station (hands-on) approaches. A program information packet with implementation materials and program resource aids is provided for program users. The target audience consists of selected students from junior high schools throughout Iowa. The program uses materials from the American Cancer Society and the American Heart Association, and employs experts such as respiratory therapists, nurses, and physicians. Program efficacy is assessed by means of pre- and postprogram questionnaires. The program is working with Iowa State University on the development of a self-reporting questionnaire.

81P-0417
Nonsmoking Program for Pregnant Young Women.
Bowers, P.
Chicago Lung Association, 1440 West Washington Boulevard, Chicago, IL 60607
Continuing.

The Nonsmoking Program for Pregnant Young Women is designed to reduce smoking among adolescent females and to reduce the impact of passive smoking on these women. A staff of consultants meets with school nurses to develop a specially designed curriculum. Materials offered for use by the nurses include films, role plays, puzzles, pamphlets, behavior change charts, and certificates of participation for students. The classroom programs developed through this inservice training project are offered to 450 young, pregnant, and unmarried women each year in groups of about 150. Implementation of the classroom sessions is coordinated with the school's health program. Pre- and postprogram tests of the pilot program have been completed, but the data have not been tabulated.

81P-0418
Ocean Alcohol Education Program.
Armstrong, E.
National Council on Alcoholism of Central New Jersey, 528 River Avenue, Lakewood, NJ 08701
Continuing.

The Ocean (New Jersey) Alcohol Education Program trains teachers and uses the "Here's Looking at You" curriculum to help elementary and high school students make responsible decisions about alcohol. The program offers teacher-training workshops; assists teachers in implementing the curriculum and evaluating its efficacy; provides individual counseling; assists in student referrals; organizes staff discussions and student rap sessions; and sponsors alcohol awareness programs for school personnel, parents, civic groups, and other community groups. The "Here's Looking at You" curriculum for grades K-12, teacher inservice training guides, and accompanying audiovisual materials were developed by the Educational Service District 121, Seattle, Washington. The curriculum employs pictures for discussion, filmstrips, films, instructional games, and student reference materials. An advisory committee is established in each school so that the program can be tailored to the needs of each student population. The target audience consists of students, teachers, and community members of the 10 major Ocean County school districts that have high schools. The individual school districts pay for the program through contracts with the National Council on Alcoholism of Central New Jersey. Programs are evaluated through subjective data collected from teachers. Washington State University at Pullman, Washington, has a grant to develop and administer objective test instruments to teachers and students and to collect, analyze, and interpret the data. A drinking-behavior instrument administered to students in junior and senior high schools and to high school graduates provides base-line data on current drinking practices.

81P-0419
PEER (Positive Educational Experiences in Relationships) Dynamics.
Harris, F. D.
Nebraska Department of Health, Division of Community Health Education, 301 Centennial Mall South, POB 95007, Lincoln, NE 68509
Funding Source: Nebraska State Dept. of Health, Lincoln; Nebraska State Dept. of Public Institutions. Lincoln. Div. on Alcoholism and Drugs.
May 1976 - Continuing.

PEER (Positive Educational Experiences in Relationships) Dynamics is a prevention program that attempts, by influencing individual emotions and values, to prevent adolescents from engaging in destructive behaviors. The program trains junior high school students in listening and communication skills and in self-awareness techniques. Methods include (1) a letter sent to all Nebraska junior

high schools offering training and consultative services; (2) yearly selection of 12 new schools for program participation; (3) correspondence with participating schools regarding their needs; (4) onsite visits to schools upon request; (5) training workshops for guidance counselors, teachers, superintendents, and principals; and (6) continued participant education through regional followup sessions. Evaluations from pre- and postprogram surveys of attitudes, grades, police contacts concerning drugs, and alcohol and drug usage have indicated an increase in overall self-esteem among program participants and a decrease in destructive behaviors.

81P-0420
Prevent-a-Care.
Morris, J. T.
Collier County Public Schools, 3710 Estey Avenue, Naples, FL 33492
1973 - Continuing.

Prevent-a-Care is designed to reduce deaths from heart disease and cancer by offering a program of early detection education in the public schools. The curricula are currently available for Collier County, Florida, students in grades 4, 6, 7, and 10. Teaching aids include a teacher resource guide, films, cartoons, slide presentations, talks and demonstrations by doctors and surgeons, and printed materials from the local American Cancer Society and American Heart Association. The program also includes an annual exposition of posters and student projects. This public event is brought about through the cooperation of local television and radio stations and newspapers. To date, more than 8,000 people have visited the annual exposition.

81P-0421
The Respiratory System and Smoking.
Bowers, P.
Chicago Lung Association, 1440 West Washington Boulevard, Chicago, IL 60607
Continuing.

The Respiratory System and Smoking curriculum is designed to help students understand the structure and function of the respiratory system and the effects of smoking on the continued health of the lungs and related organs. Topics include anatomy, physiology, and defense mechanisms of the respiratory system; effects of smoking and passive smoking; effects of smoking on the unborn baby; bronchitis, emphysema, heart disease, and lung cancer; and benefits of smoking cessation. The curriculum guide includes general information for the instructor, outlines of educational experiments, duplicating masters for teaching aids, transparencies, and a knowledge test for evaluation. The program is offered in Cook County, Illinois, high schools, and the curriculum guide is offered outside the county for a fee.

81P-0422
School Based Smoking Prevention Programs for Adolescents.
Massachusetts Department of Public Health, Division of Preventive Medicine, 600 Washington Street, Boston, MA 02111
September 1979 - June 1980.

The Massachusetts Department of Public Health conducted school-based smoking cessation programs for adolescents that (1) provided funds to public schools to implement either life skills training or peer-leadership smoking programs, and (2) measured the intervention's effectiveness by comparing base-line and followup information over a 3-year period. Approximately 4,600 students from 13 public schools participated in the program, which was usually integrated into the school curriculum. Although statistical analysis is not yet available, evaluation revealed that (1) programs were most successfully integrated when schools had a separate health education module; and (2) teachers thought that sixth and seventh graders were appropriate populations for the peer-leadership program, and seventh and eighth graders were appropriate targets for the life-skills training. Future plans include using the programs with 3,000 students in 10 Massachusetts school systems.

81P-0423
School Smoking Education Program Annual School Mailing Project.
Bowers, P.
Chicago Lung Association, 1440 West Washington Boulevard, Chicago, IL 60607
Continuing.

The School Smoking Education Program Annual School Mailing Project was designed to encourage elementary schools to participate in the National Education Week on Smoking. The project mails the materials to schools at no charge. Materials include lesson plans for teachers, game sheets for students, films, posters, and a curriculum on the respiratory system and smoking. The target audience consists of all 720,000 students enrolled in grades K-8 in the 1,400 elementary schools in Cook County, Illinois. The project is coordinated with other components of the National Education Week on Smoking project. Program ef-

ficacy will be measured by the number of schools participating and by evaluation forms received from the schools. Last year (the fourth year the program was offered), 33 percent of the schools in Cook County ordered program materials. The number of schools ordering program materials has increased each year since the project began. Feedback from the evaluation forms has indicated a high degree of participant satisfaction.

81P-0424
School Smoking Education Program Teacher In-Service Presentations.
Bowers, P.
Chicago Lung Association, 1440 West Washington Boulevard, Chicago, IL 60607
Continuing.

The School Smoking Education Program Teacher In-service Presentations project was implemented to inform teachers of current trends in smoking and to encourage them to teach about smoking in their classes. The project involves visits to schools by professional staff from the Chicago Lung Association's Smoking Section to present 30-minute inservice sessions to teachers. Teaching aids are offered at no charge. All teachers in Cook County schools are targeted for the inservice project. Sessions can include 10-200 teachers and are evaluated through feedback from principals and teachers and by the number of schools requesting inservice training. The project usually makes 10 presentations per year. Schools are generally receptive to the program.

81P-0425
Substance Abuse Education for Seventh Graders.
Miller, E. D.
Duke University Medical Center, Holistic Medicine Group, Durham, NC 27710
Funding Source: Duke Univ. School of Medicine, Durham, N.C. Medical Student Society.
April 1980 - Continuing.

The Substance Abuse Education for Seventh Graders program was designed to present students with facts about tobacco, alcohol, and drug use and abuse. The 4-day course employs lecture and discussion supplemented by posters, pamphlets, and films. Discussion of values and the psychosocial problems of adolescence is integrated into the course. The program is offered in selected science classes in Durham, North Carolina. In 1980, 5 classes with approximately 25 students in each were taught. The teaching staff consists of four medical students, one graduate student in education, and one drug education specialist. The efficiency of the program is assessed by means of verbal feedback from students, teachers, and principals.

81P-0426
TAHRG (Technical Assistance Health Resource Group) Primary Prevention Learning Model.
von Mering, O. and Mahan, C.
University of Florida College of Medicine, Department of Obstetrics and Gynecology, Technical Assistance Resource Associates, 825 N.W. 23rd Ave., Suite F-1, Gainesville, FL 32601
Funding Source: Health Services Administration (DHHS, PHS), Rockville, Md. Bureau of Community Health Services; Florida State Dept. of Health and Rehabilitation Services, Tallahassee.
1979 - Continuing.

The TAHRG (Technical Assistance Health Resource Group) Primary Prevention Learning Model is a health-service education and training group consisting of local volunteer health-care experts who join teachers in county high schools in preventive health care instruction. The overall goal is to teach students that health-related habits affect total well-being. Topics include (1) relationships of government agencies to health care delivery, (2) use of medications, (3) primary health care resources, (4) occupational health, and (5) developmental handicaps and in-home health care. A student project is required for each topic. The target audience is 10th and 11th grade students in primarily rural areas within a 13-county region with limited health resources. Staff includes volunteer health professionals, local community resource personnel, and university-based health education professionals and trainees. The program is evaluated through pre- and post-tests that measure changes in participants' attitudes, knowledge, and behaviors.

SELF-CARE

81-0427
Self-Care Programs: Their Role and Potential.
Barry, P. Z.; Pezzullo, S.; Beery, W. L.; DeFriese, G. H.; and Allen, W. J.
Chapel Hill, Univ. of North Carolina, Health Services Research Center, Health Promotion-Disease Prevention Program, 36 p., 1979.

A summary of a November 1978 conference on self-care is presented. The purpose was to achieve a better understanding of (1) the self-help movement's scope; (2) expected self-care program outcomes; and (3) proven effects of such programs in addressing health-care-system

and societal problems. Eight experts, reflecting different perspectives in the field, participated. Consensus was not sought on any agenda issue or item, in consideration of the diversity of self-care theories, objectives, and applications.

81-0428
Self-Medication Among the Elderly: A Study of Some Problems and Considerations.
Hanlon, V. M.
Calgary, Alberta, Health and Welfare, Canada, Health Promotion Directorate, 28 p., September 1, 1979.

Thirty-six elderly persons were interviewed in their homes about self-medication. The sample population consisted of members of a drop-in center and patients attending the Glenmore Park Day Hospital in Alberta, Canada. The interview schedule included 43 open-ended questions and one question that asked respondents if they knew anyone who had stopped taking medication, and, if so, why. In general, most of the subjects seemed to be experiencing few serious difficulties in managing their medications; many appeared to have effectively incorporated taking the medication into their daily routines; and most seemed to be getting no specific advice or information on certain aspects of self-medication from either their doctors or their pharmacists. This finding is not as alarming as it might seem, for only a minority of patients actually need such interventions. 6 references.

81-0429
Health Promotion-Self-Care Programs for the Community.
Nowakowski, L.
Topics in Clinical Nursing 2(2):21-27, July 1980.

Georgetown University in Washington, D.C., has developed a series of health education programs to help individuals make and implement health-related decisions. The basis of these programs is "family systems" theory, which has eight main concepts. Two of these concepts are significant to self-care programs: (1) exploring individual emotional pressures and (2) examining means of decreasing anxiety. In the Georgetown program, participants are encouraged to be more aware of strengths and self-care skills, while using the health care system for assistance. Classes are held on medications, nutrition, dental care, common illnesses and injuries, stress management, and the selection of health professionals. The interdisciplinary faculty serve as facilitators, rather than as traditional instructors, and help participants recognize their rights and responsibilities. Learning skills such as measuring blood pressure, pulse, temperature, and respiration remove some of the mystery associated with medical technology. Participants report many behavioral changes resulting from the program and frequently report plans for continued work in self-care. 10 references.

81P-0430
Arthritis Self-Management Course.
Lorig, K.
Stanford Arthritis Center, 701 Welch Road, Suite 2208, Palo Alto, CA 94304
Funding Source: Arthritis Foundation, Atlanta, Ga.; National Inst. of Arthritis, Metabolism, and Digestive Diseases (DHHS, NIH), Bethesda, Md.
1977 - 1983.

The Arthritis Self-Management Course was implemented to (1) provide arthritis patient education to the general public, (2) evaluate the outcome of arthritis patient education, (3) evaluate the effectiveness of patient education in differing health-care-delivery settings, and (4) develop a cost-effective small-group delivery system for patient education. Each 14-hour course is taught by a pair of trained lay leaders and attended by 15-20 participants; each participant is asked to bring a family member or friend. Topics include physiology of arthritis, exercise, nutrition, joint protection, physician-patient communication, relaxation, problem solving, and use of medications. The course employs lecture, discussion, demonstration-return demonstration, and brainstorming techniques. Program sites include senior centers, shopping centers, churches, senior housing projects, and bank community rooms. Over 80 courses have been given to over 1,200 participants. Evaluation is conducted through a prospective, randomized pre- and posttest design. After 8 months, results on the first 300 participants, as compared to controls, indicated a 50 percent increase in knowledge among participants, increased satisfaction with physicians, improvement in some self-management behaviors, decreased pain, improved walking ability, diminished disability among rheumatoid patients, and reduced frequency of physician visits. No significant changes were noted in locus of control, appropriateness of medication utilization, socialization, or drug costs. The program has produced a teacher's manual and has published "The Arthritis Helpbook."

81P-0431
Phoenix Society, Inc.
Breslau, A. J. 11 Rusthill Road, Levittown, PA 19056
Continuing.

The Phoenix Society is a self-help organization founded to help burn victims and their families understand and cope with burns, to increase public awareness of burn treatment and burn trauma, and to encourage positive legislative action in areas pertinent to victims. The society is a private, nonprofit organization. Phoenix members meet with the families of burn victims during hospitalization and also speak at school, college, and civic group functions to promote burn prevention and to discuss burn care and rehabilitation. Several books, films, and videocassettes on burns, disfigurement, and related subjects are available through the society. The society publishes a quarterly newsletter and promotes publication of articles in local publications. The nationwide organization consists of burn victims and their relatives, associate members interested in supporting the group, and a professional advisory board. The board includes doctors, nurses, social workers, and other community members. Voluntary contributions are the principal source of income, although a few fund-raising events have been held.

SEX EDUCATION

81-0432
Argument for Family Life and Sex Education: The Incidence of Teenage Births in Louisiana.
Cherry, F. F. and Baugh, J. G.
Journal of the Louisiana State Medical Society 131(9):227-233, September 1979.

Information is presented to enable each parish and regional planning body in Louisiana to assess the extent of childbirth by girls 14 years old and under. Data on birth rates were grouped by parish within each State health department region and included: the number of births in 1976; birth rates; percentage of births to teens; percentage of births to teens under 15; percentage of nonwhite births; trends over a 3-year period; moving 5-year average fertility rates in girls 14 years old and below and girls 15 to 19 years old (average annual number of live births in the period 1972-76 per 1,000 women in the specified age groups in 1974); and the proportion of parish to State teen births. Of the 69,998 births in 1976, 23.46 percent were to teenagers, and of these, 2.7 percent were to girls under 15 years old. Only one parish had a lower incidence of teen births than the national average. Findings suggest that early physical maturation makes it imperative for teens to have thorough knowledge of reproduction; also, societal values should be stressed to promote responsible sexuality and postponement of pregnancy until a woman reaches her 20's. Although the family is the ideal purveyor of information and values, other institutions must supplement preventive efforts. In addition, the expansion of family planning clinics' services is needed. 8 references.

81-0433
Educational Outreach: An Experimental Evaluation of Wellness Center Involvement in Classes.
Duncan, D. F.; Russell, R. D.; and Petosa, R.
Health Values: Achieving High Level Wellness 4(5):234-236, September-October 1980.

The Student Wellness Resource Center, part of the Student Health Service at Southern Illinois University at Carbondale, offers a variety of educational programs. During the summer of 1979, it was decided to improve the various media approaches to students who were unaware of or disinterested in the center's programs and to experiment with a classroom setting. A freshmen and sophomore course entitled "Healthful Living" was selected by the center to determine whether involvement by the center could be beneficial. The course covers issues related to ecology, mental health, sexuality, drugs, physical fitness, medical care, and the future of health. For each of three course instructors, one section was taught with the cooperation of the center and the other was not. Center involvement consisted of four single-class presentations on the four areas emphasized by the wellness center, i.e., alcohol education, health activation, human sexuality, and lifestyle. All experimental and control sections completed a pretest during the first 2 weeks of the semester and a posttest during the last 2 weeks. The experimental group performed significantly better than the control group on the pre- and posttest scores. Results suggest center involvement produced meaningful benefits in terms of knowledge gains and short-term health effects. See also 81-0404 and 81-0405.

81-0434
Sex Education in Italy.
Forleo, R. and Lucisano, P.
Journal of Sex Education and Therapy 6(1):14-18, Summer 1980.

An overview of the history of sex education in Italy indicates that a successful program must involve the family, church, and school, and youth clubs, family advice bureaus, and local health units. In the earliest efforts, sex education was connected to both government and feminist efforts to integrate the sexes in the school system. The modern approach to sexology, promoting the interdisci-

plinary and broad scope of sexuality with such topics as affection, friendship, compassion, and parental sentiment, began after World War I. The influence of Mounier's thought and the work of several Catholic scholars helped create positive attitudes toward sexology and, after the fall of the fascist regime in World War II, the church began to move toward the liberal position outlined in the Second Vatican Council. The 1960's were marked by pioneering initiatives, as Catholics began to contribute to the subject, and further education and guidance for adults became available. The 1970's could be defined by the student takeover of the sexual issue and by the introduction of legislative measures by the three political parties.

81-0435
Family Planning and the Young Minority Male: A Pilot Project.
Johnson, L. B. and Staples, R. E.
Family Coordinator 28(4):535-543, October 1979.

Recognizing the need for a family-life education and family-planning delivery system for inner city minority males, the Los Angeles Young Inner-City Males Project was initiated to serve blacks, Chicanos, Asians, and Native Americans living in poverty areas. To enlist the cooperation of agencies in the 4,000 square-mile service area, Naomi Gray Associates, a minority-owned health consulting firm, worked in cooperation with the Los Angeles Regional Family Planning Council. The project is staffed by a director, a project coordinator, a Spanish-speaking consultant, four outreach counselors, and six peer group counselors. With the exception of the Asian community, each ethnic community has a peer outreach counselor who works within the participating agency. A 21-member consumer advisory committee works with the staff in evaluating educational materials, giving feedback on program effectiveness, suggesting new programs, and serving as a sounding board for pertinent issues. After 16 hours of formal training, each outreach counselor works 10 hours per week in an attempt to attract males to established clinics and to improve noninstitutional delivery services. Within 3 months, the staff contacted 437 young persons, 83 adults, and 73 agencies. The effectiveness of the project demonstrates the need to involve the minority male more directly in decisions about sex and parenthood. 24 references.

81-0436
The Experts Rate Important Features and Outcomes of Sex Education Programs.
Kirby, D. and Alter, J.
Journal of School Health 50(9):497-502, November 1980.

A study involving students in sex education classes and sex education professionals was designed to rate and assess the outcomes of sex education programs and features of the programs contributing to the outcomes. A review of the literature and interviews with experts and students produced a list of 147 program features and 92 program outcomes. Nine prominent educators selected 215 professionals to determine the importance of the program features and outcomes; 100 responded. Half of the professionals rated each item according to its importance in reducing teenage pregnancy, while the other half rated each item according to its importance in facilitating positive attitudes toward sexuality. The experts' ratings indicated that program features addressing sexual behavior, contraception, myths, values, exploitation and assertiveness, and emotional and social aspects of sexuality were thought to be most important. Program outcomes considered by experts and students to be most important include knowledge of sexuality and sexual physiology and functioning, an understanding of the self, acceptance of changes and differences in values, attainment of greater sexual self-esteem, and acceptance of the positive role of sexuality in one's life. Overall, there was considerable agreement between the experts and the students concerning important features and outcomes. 5 references.

81-0437
Human Sexuality Services: A Holistic Approach to Sex Education and Counseling in a University Setting.
Landis, S. M.
Health Values: Achieving High Level Wellness 4(5):229-233, September-October 1980.

The Human Sexuality Services Program, implemented in 1972 at Southern Illinois University at Carbondale, offers a preventive and holistic approach to sex education and counseling. The major program components are counseling, educational programming, training, and program evaluation. Approximately 400 students voluntarily seek counseling each year for problems such as unwanted pregnancy, conflicts about becoming sexually active, sexual dysfunction, and venereal disease. Educational efforts include classroom lectures, ongoing discussion-group meetings, weekend workshops, and informal rap sessions held in residence hall lounges. The program's professional training component allows students seeking degrees in the health fields to complete practicums and internships and to obtain field placement. The program is evaluated through interpretation of data from self-report forms gathered after individual and group counseling sessions, workshops, and weekend programs. Outcome evaluations have been conducted on the birth-control residence programs, and several research studies have been conducted on sexual-awareness weekend workshops.

81-0438
How We Guarantee the Ineffectiveness of Sex Education.
Scales, P.
SIECUS Report 6(4):1-3, March 1978.

A review of pertinent research indicates that most hypotheses concerning the bad effects of sex education are false and impede effective implementation of school-based sex education programs. Researchers have found that people do not become more liberal or permissive in their attitudes as a result of sex education. Knowledge about sexuality is not associated with sex-related crime or with significant changes in the frequency or variety of a person's sexual behavior. In all areas of the world, the highest fertility rates are associated with low levels of education, inadequate knowledge about conception and contraception, and the inferior status of women. Young people who accept their sexuality are more likely to use contraception than those who are guilty about or fearful of expressing themselves sexually. Making students feel guilty about sexual behavior, instead of encouraging them to act responsively, probably undermines the beneficial effects of sex education. Improvement of current programs will require passing State laws that mandate sex education courses in public schools and provision of contraceptive services to adolescents. 17 references.

81-0439
The Context of Sex Education and the Reduction of Teen-age Pregnancy.
Scales, P.
Child Welfare 58(4):263-273, April 1979.

Literature on the reduction of teenage pregnancy through sex education is reviewed. Topics include systems of morality and values; peer education and peer counseling approaches; media coverage of sexuality, including National Family Sex Education Week, the use of rock music, high school newspapers, and live theater; the use of medical students as information providers; and parental sex education programs. Addressing the problem of teenage pregnancy is becoming a social movement, and most adults are beginning to acknowledge that sex education is beneficial. Adults must provide insights into sex roles, sources of personal respect and worth, communication skills, and the meaning of parenthood. 38 references.

81-0440
Barriers to Sex Education.
Scales, P.
Journal of School Health 50(6):337-341, August 1980.

A review of the literature provides a list of barriers to sex education, presents evidence of successful management of opposing views, and demonstrates how program sponsors can assess their community's readiness for a sex education program and organize it for maximum political viability. Such an assessment provides an overall estimate of the likelihood of program implementation and identifies specific issues that may strengthen or weaken the program. 13 references.

81-0441
Programs for Sexually Active Teens.
Smith, P. B.
In: Adolescent Pregnancy: Perspectives for the Health Professional. Smith, P. B. and Mumford, D. M., eds. Boston, G. K. Hall, p. 77-97, 1980.

In the 1960's, approximately 30 projects that addressed the needs of sexually active or pregnant adolescents were initiated; by 1978 over 900 such projects had been established. A typical hospital-based program incorporates a multidisciplinary design, involves health maintenance for the mother and child, encourages continuation of the mother's education, and promotes the use of contraceptives. Community-based programs can be organized in diverse settings, including churches, mobile classrooms, health centers, and shopping centers. In response to the fact that pregnancy is the most frequently stated reason for the termination of formal schooling, school programs have included a variety of formats, such as homebound education, special school placement, night school, and closed-circuit television. The availability of pregnancy testing in the school setting, a service which could easily be performed by the school nurse, would widen the variety of counseling options and service entry points. Though still controversial, clinical programs for nonpregnant teenagers continue to develop, either as components of multidisciplinary, holistic programs or as programs with a focus on contraception services. Finally, though rap session services and free distribution of condoms are the chief forms of contraceptive programs for teenage males, recent studies have indicated the importance of the teenage male in family planning. 66 references.

81-0442
Teaching and Learning About Sexuality and Aging.
Steffl, B. M. and Kelly, J. J.
Educational Gerontology 4(4):377-388, October-December 1979.

An undergraduate course on sexuality and aging is examined. Major topics covered are research findings regarding

physiology and physical changes, sex and the aging male, sex and the aging female, and common misconceptions about age and sex. The course uses lectures, discussions, films, slide programs, student reports, field trips, and two selected textbooks. Three suggested activities or areas of discussion added to the course and recommended for experiential teaching-learning are (1) shared experiences of older persons, who are often more willing and comfortable in discussing sexuality than many young people; (2) student views and activities, beginning with discussions of past, present, and future attitudes about sexuality, and student surveys or research on opinions or problems, which may be shared in class; and (3) field trips to stores or shops that sell aphrodisiacs, sex devices, and pornographic films, and to sexually oriented theaters or clubs. Course findings, which have implications for gerontology educators, are presented. 9 references.

81-0443
10 Commandments for Parents Providing Sex Education.
van Emde Boas, C.
Journal of Sex Education and Therapy 6(1):19, Summer 1980.

Ten directives for parents providing sex education for their children are presented. The directives emphasize a holistic approach which encourages spontaneous sexual expression by the child and role modeling by the parent. Truth and a nonexploitative attitude toward sexuality are essential. Biological facts should not be stressed at the expense of the emotional and relational aspects. Discussion of contraception may be necessary very early in a child's sexual education. Finally, formal sex education can be no more than an adjunct to sex education within the family.

81P-0444
Adolescent Pregnancy Project.
Fairley, C.
New York State Education Department, Bureau of School Health Education and Services, State Education Building, Albany, NY 12234
January 1979 - Continuing.

The Adolescent Pregnancy Project was initiated to develop a comprehensive process to help school districts implement their own adolescent pregnancy programs. Components of the program include a family life and human sexuality education curriculum for students in grades K-12; a family life and human sexuality education curriculum for adults, school-aged parents, and expectant parents who want to teach their children; a parenting education program to provide parents and prospective parents with knowledge and skills to meet the physical, emotional, and developmental needs of their children; and education programs for school-age students who are pregnant, prospective fathers, or parents. The program provides teacher training and parent education workshops, prepares curriculum and resource guides, and develops and purchases materials for staff members and students. Programs for individual school districts are developed after needs and resources are assessed and a local advisory council makes recommendations. The program is available to all school districts within the State of New York. Five Boards of Cooperative Educational Services (BOCES), 21 school districts, and the special education department of one BOCES are involved in one or more components of the project. Over 47,000 students, 600 teachers, and 800 parents have participated in one or more components of the program. More than 75 local community agencies have been directly involved, and more than 112 local agencies are involved indirectly in program activities. A survey of family life and sex education programs in the State's schools is being developed in collaboration with the New York State Department of Social Services.

81P-0445
Human Sexuality and Adolescence.
Miller, E. D.
Duke University Medical Center, Sex Education Committee, Durham, NC 27710
Funding Source: Duke Univ. School of Medicine, Durham, N.C. Davison Society; Duke Univ. School of Medicine, Durham, N.C. Medical Education Fund.
Continuing.

The "Human Sexuality and Adolescence" course was designed to present basic facts, give adolescents an outlet for their natural curiosity about their bodies, reduce students' anxiety concerning sexual matters, and encourage students to explore their own values. The course involves 6 days of lecture on factual material and 2 days of group discussion on the psychological and social problems of adolescence. A training symposium is offered before each course. Teaching aids include quizzes, worksheets, diagrams, pamphlets, films, and a box for anonymous questions. In 1980, the program reached 425 seventh grade students in 17 science classes. Teachers included 28 medical students, 3 nursing students, and 3 physician's assistant students. Other projects of the Duke University Medical Center Sex Education Committee include a course for Trinity College undergraduates and a course for high school students.

81P-0446
Parents as Sex Educators.
Rolnick, C.
Midwest Health Center for Women, 825 South 8th Street, Suite 902, Minneapolis, MN 55404
Continuing.

"Parents as Sex Educators" is designed to help parents become more open to their children's questions about sex and sexuality. The program consists of three sessions, each lasting approximately 2 hours, in which parents examine their level of "approachability," explore their attitudes toward sexuality, and review available resource materials for various age groups.

81P-0447
Project ESTEEM.
Irwin, M.
YWCA Urban Center, 1130 Nicollet Avenue, Minneapolis, MN 55403
Funding Source: Minneapolis Community Action Agency, Minn.
August 1979 - Continuing.

Project ESTEEM is a teenage-pregnancy intervention program created in response to the rising rate of teenage pregnancy and its effects on the lives of youth and the social structure in which they live. The program attempts to build self-confidence in adolescents; provide awareness of lifestyle alternatives; and provide information on sexuality, parenting, values, and decision making. Program components include (1) education through informational presentations and curriculum development; (2) one-to-one and small group counseling in schools, churches, and other community agencies on sexual health issues; (3) challenging experiences, such as field trips and discussions of intimacy, through which youths can build their self-images and feelings of self-worth; and (4) the training of peer counselors to advise adult staff on recruiting participants and conducting small groups with youth counselors. The program staff includes four youth counselors, two educational coordinators, and five peer counselors.

81P-0448
Two Together: Doing It, Feeling It, Sharing It.
Betz-Ellis, J.
Midwest Health Center for Women, 825 South 8th Street, Suite 902, Minneapolis, MN 55404
1978 - Continuing.

The Two Together program of Minneapolis is a health and sex education outreach program designed to explore adolescent sexuality and decision making. The program, administered by a private, nonprofit organization, involves four 2-hour sessions addressing sexual maturation, sexual decision making, responsible sexual relationships, and parenting and contraception. Small group discussion and audiovisual materials are the primary teaching methods. Sessions are codirected by male and female counselors. Target groups include teenagers residing in treatment centers, group homes, correctional facilities, alternative schools, and community centers. Sessions have also been held in high schools.

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This special issue contains descriptions of the State-level and local intervention projects funded by the Health Education-Risk Reduction Grant Program.

INTRODUCTION

Current Awareness in Health Education (CAHE) is published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents acquired and selected by the Center. CAHE also contains descriptions of programs in health education. These descriptions are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources. To make the information in CAHE timely, only documents publisned or programs of relevance since 1977 are included.

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Tearsheets for submitting program documents and descriptions of relevant programs are provided on pages vii-viii.

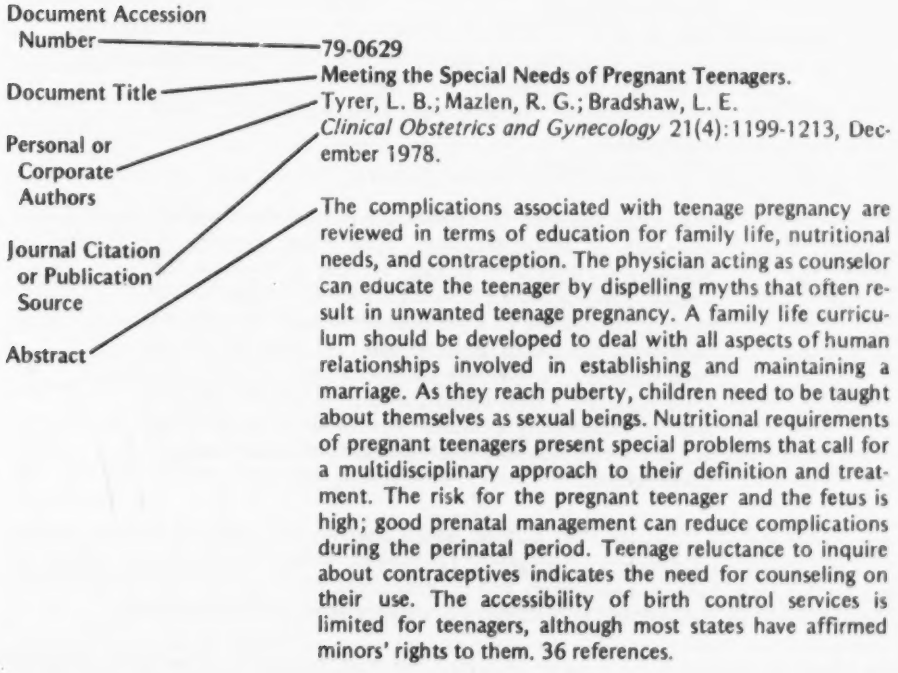
HOW TO USE CAHE

CAHE contains two types of records: informative abstracts of published literature and descriptions of ongoing programs. These records are arranged in chapters according to their major subject area. Chapter headings are used to group items generally related and include: Community Health Education; Health Education in Occupational Settings; Health Education Methodology; Patient Education; Professional Education and Training; Regulation, Legislation, and Administration; Research and Evaluation; Risk Reduction; School Health Education; Self-Care; and Sex Education. The chapter headings reflect active areas in health education as well as major interests of the Center for Health Promotion and Education. To locate specific items of interest, users are encouraged to use the extensive Subject, Author, and Program Title indexes found in the back of each issue.

Within each chapter, citations and abstracts of documents appear first, followed by descriptions of programs. Abstracts with their citations are arranged in alphabetical order by the primary author's name, and descriptions of programs are arranged in alphabetical order by the title of the program.

Each document and program description has a unique accession number. Accession numbers of documents consist of a two-digit prefix indicating the year of acquisition by CAHE and a four-digit number indicating the publication sequence of the document. For example, 79-0022 indicates the 22nd document acquired by CAHE in 1979. Program accession numbers have a similar format with a "P" added following the year to indicate program, e.g., 79P-0025 indicates the 25th item acquired by CAHE in 1979, and that the item is a program.

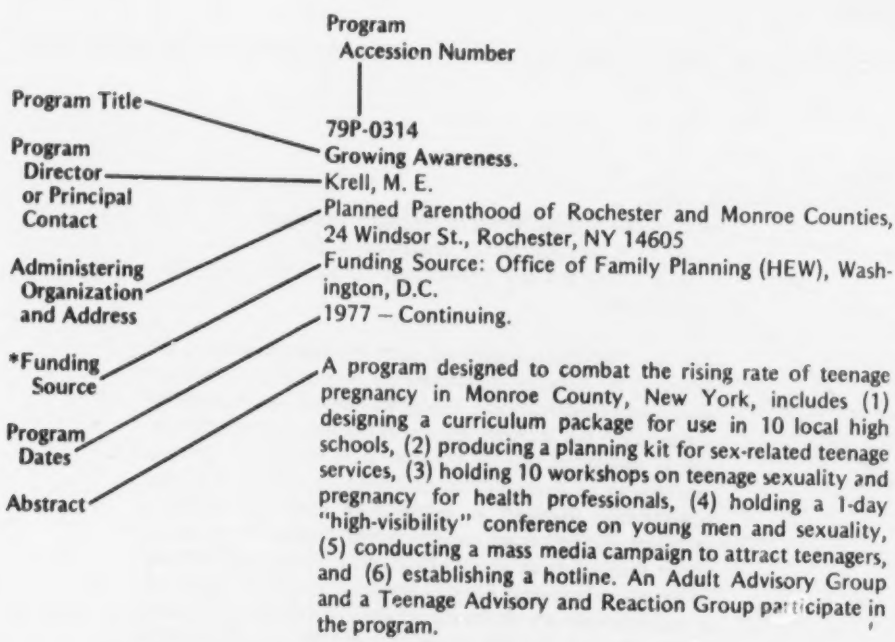
Each document is uniformly identified and described by the elements labeled in the sample below:


Document Accession Number
79-0629
Document Title
Meeting the Special Needs of Pregnant Teenagers.
Personal or Corporate Authors
Tyrer, L. B.; Mazlen, R. G.; Bradshaw, L. E.
Journal Citation or Publication Source
Clinical Obstetrics and Gynecology 21(4):1199-1213, December 1978.
Abstract
The complications associated with teenage pregnancy are reviewed in terms of education for family life, nutritional needs, and contraception. The physician acting as counselor can educate the teenager by dispelling myths that often result in unwanted teenage pregnancy. A family life curriculum should be developed to deal with all aspects of human relationships involved in establishing and maintaining a marriage. As they reach puberty, children need to be taught about themselves as sexual beings. Nutritional requirements of pregnant teenagers present special problems that call for a multidisciplinary approach to their definition and treatment. The risk for the pregnant teenager and the fetus is high; good prenatal management can reduce complications during the perinatal period. Teenage reluctance to inquire about contraceptives indicates the need for counseling on their use. The accessibility of birth control services is limited for teenagers, although most states have affirmed minors' rights to them. 36 references.

The distributor from which a document cited in CAHE is available to the public may be given as the last element in the citation. The most commonly cited distributors and their acronyms are listed below. Price information may be obtained from the supplier at the address given by specifying the order or stock number of the document and the form, hard copy or microfiche, desired. If the document is available from a distributor other than those listed, such as directly from the author, the address of that alternate distributor is provided.

Available from GPO:	Document is sold by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, in hard copy.
Available from ERIC:	Document is available from the Educational Resources Information Center Document Reproduction Service (EDRS), P.O. Box 190, Arlington, VA 22210, in hard copy or microfiche.
Available from NTIS:	Document may be purchased from the National Technical Information Service, U.S. Department of Commerce, Springfield, VA 22161, in hard copy or microfiche.

Each program description is uniformly identified and described by the elements labeled in the sample below:


Program Accession Number
Program Title
Program Director or Principal Contact
Administering Organization and Address
*Funding Source
Program Dates
Abstract
79P-0314
Growing Awareness.
Krell, M. E.
Planned Parenthood of Rochester and Monroe Counties, 24 Windsor St., Rochester, NY 14605
Funding Source: Office of Family Planning (HEW), Washington, D.C.
1977 – Continuing.
A program designed to combat the rising rate of teenage pregnancy in Monroe County, New York, includes (1) designing a curriculum package for use in 10 local high schools, (2) producing a planning kit for sex-related teenage services, (3) holding 10 workshops on teenage sexuality and pregnancy for health professionals, (4) holding a 1-day "high-visibility" conference on young men and sexuality, (5) conducting a mass media campaign to attract teenagers, and (6) establishing a hotline. An Adult Advisory Group and a Teenage Advisory and Reaction Group participate in the program.

CAHE contains three indexes. They are: (1) Author, which contains the names of personal and corporate authors of documents and directors of programs; (2) Subject, which contains subject descriptors, including geographic location, for both documents and programs; and (3) Program Title, which contains names of programs that are either mentioned in documents or detailed in program descriptions.

*The funding source is specified if the program receives funds from institutions other than the administering organization.

PROGRAM DATA SHEET

The Center for Health Promotion and Education is collecting information about current health education programs for use in *Current Awareness in Health Education* and in analyzing program trends in the field. A program may provide identification, public awareness, coordination, training, demonstration, etc.

If you wish to share your program efforts with other health education professionals, please complete the form below, being as specific as possible in providing information.

We greatly appreciate your taking the time to share your experience with us.

---

1. Program Identification:

   Official Title of Program or Grant and Grant No: _____

   Official Name of the Organization Conducting the Program: _____

   _____

   Address of the Organization:

   _____

   street city state zip code

   Program Director: _____

   name title telephone area code number

   Principal Contact: _____
   (if different from Program Director)
   name title telephone area code number

   Beginning Date of Program: _____ Ending Date, If known: _____

2. Funding Source for Your Program:

   Please provide the Name(s) and Location(s) (City, State) of Funding Source(s):

   _____

   _____

   _____

3. Focus of Program: _____Administration _____Community Health Education _____Health Education Methodology

   _____Nutrition Education _____Occupational Health Education _____Patient Education

   _____Professional Training Programs _____Research and Evaluation _____Risk Reduction _____Sex Education

   _____School Health Education Other _____

4. Target Population(s): _____

5. Purpose of Program: Please describe the primary purpose of your program

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Publications/Information Materials: Please send copies of any publications or material describing your program, if available, or give complete citation (author, title, date, publisher). If no publications exist or are planned, please state how further information may be obtained.

   _____

   _____

   _____

   _____

   _____

THANK YOU.

Name, Title of Person Submitting Program Information

Organization

Street

City, State, Zip Code

Phone

Fold Here First

Place stamp here

Centers for Disease Control
Center for Health Promotion and Education
ATTN: Current Awareness in Health Education
Atlanta, GA 30333

Fold Here

(Please cut along dotted line)

Staple or Tape

ALABAMA

81P-0449
Health Education-Risk Reduction (HERR) Grant Project, Alabama.
McVay, J. M.
Alabama Department of Public Health, Bureau of Primary Prevention, No. 206 State Office Building, Montgomery, AL 36130
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Alabama was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The inventory of existing HERR programs will be updated quarterly and revised for printing annually. Lists of potentially complementary programs will be solicited from the Alabama Development Office, State health planning agencies, HSA's, HMO's, emergency medical councils, education organizations and associations, and health-related associations. Information will be sought from industry. Additional inventories will be made of funded local intervention projects. A letter-questionnaire will be sent to identified organizations to update or complete information. This information will be printed in a directory. The State health department's monthly newsletter will advertise the availability of the directory. Relations will be strengthened between the HERR program staff and others involved with risk reduction by continued participation in the health education section of the Alabama Public Health Association; the American Alliance for Health, Physical Education, Recreation and Dance; and other local business and civic organizations. An advisory group will be formed from representatives of State departments, the PTA, HSA's, volunteer agencies, and intervention projects. This group will assist the HERR State staff in long-range plannings, in refinement of the scope and magnitude of the local intervention projects, and in evaluation as a peer review committee for local intervention projects. CDC Common Data Items will serve as the basis for determining prevalence of risk factors. Further field testing will be made of a survey instrument to determine the prevalence of smoking among elementary, junior, and senior high school students. This instrument was developed in conjunction with the American Cancer Society. In cooperation with the Seventh Day Adventist Church, a method for determining recidivism will be established. The Automated Classification of Medical Entities (ACME) program will be purchased. Attempts will be made to add smoking questions on cancer reporting forms, obtain data from hypertension screenings, followup on data reported from maternity clinics, and seek information from other State agencies. The State HERR will provide technical assistance by coordinating community organizations and identifying mutual interests. Survey instruments and assistance in writing and implementing workplans will also be provided through workshops.

81P-0450
Macon-Bullock Counties Health Education-Risk Reduction Intervention Activity Project.
Tuskegee Area Health Education Center, Auburn University. Department of Health, Physical Education, and Recreation and School of Education, AL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Macon-Bullock Counties Health Education-Risk Reduction Intervention Activity Project is designed to (1) conduct a 4-year longitudinal study to document smoking and alcohol acquisition patterns in minority adolescents; (2) document educational approaches that facilitate informed decisions about tobacco use, alcohol consumption, and health habits; (3) relate personality variables to smoking and alcohol use and nonuse behavior of rural minority youth, 13-18 years old; and (4) study the relationships between early use of tobacco and alcohol and the high incidence of chronic disorders found in rural nonwhite populations. The program will be conducted through (1) educational intervention programs utilizing a new school curriculum, counseling, and a youth health forum; (2) a risk reduction program utilizing a youth enrichment program, an eight-session behavior modification program, youth training, a news column, parent community workshops, and youth fitness clubs; and (3) a survey to determine the prevalence of risk factors. The target group consists of Bullock County students, grades K-12 (2,226 estimated enrollment) and Macon County students, grades K-12 (4,947 estimated enrollment). Both school systems are predominantly black. Evaluation will

be conducted through process evaluation; impact evaluation (time-series design before and after intervention); and outcome evaluation of in-school curricula and behavior modification.

81P-0451
Mobile County Health Education-Risk Reduction Intervention Activity Project.
Franklin Memorial Primary Health Center, AL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Mobile County Health Education-Risk Reduction Intervention Activity Project is designed to (1) involve the 7,669 children and adolescents in the Davis Avenue area in a 1-year educational program to deter smoking and the use of alcohol, and (2) increase the knowledge of other Davis Avenue community residents on the health hazards caused by smoking and alcohol abuse. To accomplish these goals, the project will (1) conduct a survey of the student population, (2) examine health data for a sample of the adult population, (3) prepare audiovisual materials, (4) formulate a youth program, (5) publish a manual of health programs, and (6) establish regular screening programs. The target group consists of the Davis Avenue community, estimated at 20,174, 94.1 percent of whom are black. Evaluation will be conducted through (1) analysis with the Centers for Disease Control's common data items, (2) before-and-after comparisons, (3) questionnaires of students to ascertain changes in behavioral patterns, and (4) a health risk survey.

ALASKA

81P-0452
Health Education-Risk Reduction (HERR) Grant Project, Alaska.
Glocke, S. B.
Alaska Department of Health and Social Services, Division of Public Health, Health Education Office, Pouch H 06H, Juneau, AK 99811
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Alaska was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By March 1981 the State will inventory nonschool-based programs and services. During November 1980 an HERR coordinator will be hired and criteria defining HERR services will be developed in cooperation with HSA's. By December an HERR service survey instrument will be designed and circulated during January 1981 for review by key agencies to elicit their cooperation in identifying other agencies to be surveyed. During February the questionnaire will be finalized and sent to agencies. By March the data will be tabulated and analyzed. Between October 1980 and January 1981, existing risk reduction programs and curricula in Alaska schools will be inventoried. The instrument will be developed in cooperation with the Department of Education, which will help define criteria for HERR programs. In FY 1981, a clearinghouse for HERR services will be established in the Division of Public Health, Health Education Office, with procedures for responding to information requests and keeping the inventory current. A directory will be distributed to all participating agencies and schools; a news release on the survey results and information on how to access the data will also be prepared. In FY 1981 relationships will be established with agencies and organizations interested in risk reduction activities through: consultations to initiate the clearinghouse for risk reduction activities; a quarterly bulletin to highlight individual HERR projects (current and updates of inventory information); and provision of technical assistance to communities. During FY 1981 a method to determine prevalence of risk factors (alcohol, smoking, obesity, stress, and high blood pressure) will be developed. For this process, inhouse and outside data sources will be reviewed; the CDC-recommended Common Data Items will be assessed for their relevance in Alaska; research methodology will be developed and finalized; and a storage and retrieval mechanism will be established. Existing sources of data relating to chronic disease morbidity-mortality will be identified and permission to access data from relevant sources will be negotiated. Interactions with relevant agencies will be ongoing. Specific risk reduction factors will be identified. Annually, at least two target groups will be surveyed for one or more risk factors to determine change in incidence or prevalence rates in cooperation with communities or organizations. The morbidity and mortality trends of certain chronic diseases will be correlated with the updated risk factor and prevalency data. Technical assistance in sampling, survey design, and statistical analysis will be provided to community organizations requesting help in chronic disease surveillance activities. During FY 1981 there will be interaction with communities to stimulate

and assist communities to undertake an organized approach to risk reduction.

81P-0453
PHS-CDC Health Education Program.
Ketchikan Indian Corporation and the Ketchikan Comprehensive Alcoholism Program, Ketchikan, AK
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The PHS-CDC Health Education Program is designed to (1) develop a comprehensive health education program for grades K-12 in the Ketchikan Gateway Borough, (2) encourage wellness-oriented health promotion in target population youth (youth 14-17 years old in the borough), (3) develop coordination of all substance abuse intervention programs, (4) develop a centralized resource of health education materials and information, (5) develop an interagency joint steering committee to coordinate community involvement on health education and risk intervention activities, (6) reduce by 50 percent the number of high school expulsions due to substance abuse-related problems, (7) reduce by 20 percent the incidence of substance abuse resulting in disruption of the educational process or social disturbances, and (8) reduce by 20 percent the recidivism rate of substance abusers in the high school population. The program will be conducted through (1) identifying and testing various interventions; (2) increasing public awareness of wellness through materials circulated to parents, teachers, and students; (3) mobilizing peer group pressure; (4) developing an annotated bibliography of health education texts and articles; (5) developing a depository of audiovisual materials for use by teachers and health educators; (6) developing curricula and attendant lesson plans for grades 7-12; (7) reviewing and selecting printed materials to determine their cultural and social acceptability and educational usefulness; (8) establishing a policy-making body for health education activities, composed of representatives from various community agencies, to establish priorities for health education activities; (9) establishing regular instruments of interagency communication; and (10) providing better identification and referral services for assessment, evaluation, intervention, and treatment of youths at risk of high school expulsion. The health educator will assess and review the programs on a comparative basis and according to previously defined standards and criteria. Those programs determined most effective will be retained. Teacher assessment and comments on classroom performance of the students will also have a substantial influence upon those projects selected for retention.

81P-0454
Smoking and Alcohol Intervention for Youth in Schools and Eskimo Villages.
Health Education Department of Norton Sound Health Corporation, AK
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Intervention program is designed to (1) recruit and train 30 youths to promote health among their peers; (2) reduce by 10 percent the number of teenagers who become heavy alcohol users and to maintain this reduction for 5 years; (3) reduce the number of children under 14 years old who begin to smoke and drink; (4) introduce healthy behaviors among teenagers, including good nutrition, physical fitness, stress reduction, and effective communication; (5) provide parents and community health aides with skills to help children and teenagers deal with pressures; (6) initiate a self-evaluation program involving pre- and posttraining tests for youth health promoters, effectiveness surveys for youth health-promoter training classes, teen center health workshops, health festivals, and an adolescent health survey preceding the intervention program and at yearly intervals thereafter; (7) perform impact clinic visits for respiratory problems among children and teenage smokers; and (8) include 4 new villages in the program each year. The program will be conducted through (1) health festivals operated by youth health promoters; (2) youth health promoters as group facilitators in schools, agencies, and clubs; (3) a series of 6 workshops to promote healthy behavior among youth; (4) hospital work-study experience as a healthy alternative to smoking and alcohol; and (5) evening workshops conducted by adult counselors in villages. The target group includes 1,500 children and adolescents in Nome and surrounding communities. Evaluation will be conducted through pre- and posttraining tests to assess knowledge and ability of youth health promoters, self-evaluation of participants, attendance counts at health festivals and responses of participants, an adolescent health survey, and a quarterly evaluation of adolescent behavioral changes.

ARIZONA

81P-0455
Health Education-Risk Reduction (HERR) Grant Project, Arizona.
Martin, F.
Arizona Department of Health Services, Office of Health Education, 1740 W. Adams Street, Phoenix, AZ 85007
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Arizona was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. In FY 1981 the statewide inventory document, developed in FY 1980, will be reviewed by Task Force Members of the Arizona Health Promotion Alliance. The Alliance will be chaired by the Project Director, and composed of representatives from each CDC-funded intervention project, representatives from appropriate State agency offices--Chronic Disease and Epidemiology, Nutrition, Vital Statistics--and other appropriate State agencies and health promotion programs. The Alliance will recommend plans for the annual revision, expansion, utilization, and updating of the inventory which will cover all Arizona counties. The Alliance will review and approve revised criteria for an inclusion definition, an instrument and methodology for information collection, identification of additional agencies to be inventoried, methods of updating, and plans for utilizing and distributing the inventory. The Alliance was created to coordinate the interaction and interrelationships needed for the success of this project. Methods to build these relationships include Alliance meetings, a newsletter, publication of the annual request for proposals, and contract-monitoring activities. Evaluation of the progress will be evidenced by the representation on the membership list, products acted on by the Alliance, documentation of cooperative relationships, and new programs. A Task Force of the Alliance--The Risk Factor Prevalence Task Force--involving local, voluntary, private, and public agencies and organizations will develop an instrument incorporating the Common Data Items recommended by CDC for collection and use of risk factor prevalence data, a data collection plan, and evaluation strategies for use by Alliance members and others by September 15, 1981. The instrument will be used in all CDC-funded projects. All agencies will have access to the data, and assistance on utilizing data sources will be provided to CDC-funded projects and to other communities as resources permit. Specific chronic disease reduction data identified during FY 1980 will be acquired and reviewed by a Task Force of the Alliance. An acceptable plan, chosen from alternatives, for the ongoing collection of pertinent chronic disease and risk factor data will be developed and recommended by the Alliance by September 30, 1981. In FY 1981 to stimulate, assist, facilitate, and ensure the utilization of an organized approach by the CDC-funded projects and communities planning for the risk reduction activities, the 1981 contracts with local projects will specify the need for documentation of the organized approach strategies in implementing risk reduction activities; all publications and communications will emphasize an organized approach strategy; local and State reports will identify, document, and profile communities utilizing the organized approach.

81P-0456

Alcohol-Smoking Intervention Prevention (ASIP) and Nutrition Awareness (NA) Program.

Western Arizona Health Concepts, Inc., AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Alcohol-Smoking Intervention Prevention (ASIP) Program is designed to (1) establish base-line data for smoking, alcohol use, and other health risks among students; (2) reduce the incidence of smoking among students, especially those in grades 6-8 and native American and Hispanic students, through classroom teaching; media campaigns; and the development of values-clarification skills, decision-making skills, and positive peer relationships; and (3) provide medical treatment programs for students who want to stop smoking and drinking. Methods will include (1) data collection using the Centers for Disease Control's common data items; (2) classroom instruction of students in grades 6-8 that encourages creative involvement; (3) a community-wide mass media effort, with messages prepared by students and staff; (4) group meetings with native American and Hispanic students; (5) medical intervention consisting of group therapy, self-hypnosis, visualization techniques, and biofeedback; and (6) funds solicitation to encourage additional community support. The Nutrition Awareness (NA) Program is designed to (1) provide nutrition education and reduce health-related risks due to diabetes, alcoholism, obesity, inadequate nutrition, and other community problems and diseases; (2) establish base-line nutrition data using health hazard appraisal forms; and (3) provide a tribal nutrition education program, bilingual nutrition education materials, professional training in diabetes to tribal health care providers, a paraprofessional program for health promotion to be conducted on reservations, stimulation for tribal athletic programs, and a referral service for diabetics. Activities will include health hazard appraisal, distribution of educational materials, preparation of materials for elders, nutrition workshops, values-clarification teaching modules, outreach nutrition services to reservations, athletic programs, coordination of tribal health programs, and group meetings. The ASIP target group consists of 6,392 students in grades 6-9 in Mojave and Yuma County schools; the NA target group consists of 6,000 native Americans in 6 tribes in western Arizona. Annually, prevalence of nutrition-related deficits will be projected, baseline data will be assembled, and health status indicators will be measured. Athletic activities will be monitored semiannually, barriers to nutritional program benefits will be monitored quarterly, and tribal councils and health committees will evaluate program acceptance and success.

81P-0457

Better Health Through Self-Awareness, a Multi-Agency Cooperative Program.

Pima County Health Department, Chronic Disease Division, Tucson, AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Better Health Through Self-Awareness program is designed to (1) implement a demonstration program to deter adolescents from smoking and alcohol abuse, to serve as a model for other community schools and agencies; (2) demonstrate the effectiveness of an intervention strategy for reducing health hazards among hypertensives; (3) initiate behaviors that will result in lowered blood pressures; (4) initiate a network of agencies to improve the health habits of Pima County residents; and (5) increase public awareness of the health hazards of smoking, alcohol abuse, obesity, hypertension, stress, and other risk factors. The program has three components. The first consists of the Alternative School Project, the Hypertension Intervention Program, and Community Health Education; together, these programs will provide meditation instruction in the classroom, workshops on the harmful effects of certain behaviors, group training and individual assistance in hypertension control, and chronic disease prevention education. The second component is a school-based program to reduce smoking and drinking. The third component is a health status survey; although each component will have its own evaluation component, the survey will link all components. It will sample 2,000 Pima County residents to determine the prevalence of risk factors, and this prevalence will be reassessed periodically. The target group consists of students in 7 junior and senior high schools in Pima County, totaling approximately 250 students; persons on the Pima County health hypertension case registry, totaling approximately 750 persons; and as many people as can be reached in Pima County.

81P-0458

Comprehensive Cardiovascular Program.

Coconino County Department of Public Health, Flagstaff, AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Comprehensive Cardiovascular Program is designed to (1) reduce premature death and disability caused by cardiovascular disease (CVD); (2) increase knowledge and awareness among Coconino County residents of the health hazards related to obesity, hypertension, physical inactivity, stress, and dietary factors and their relationships to cardiovascular disease; (3) reduce the incidence and prevalence of CVD risk factors; and (4) provide especially vulnerable groups, such as low-income or ethnic pregnant women and their children, the opportunity to make informed decisions regarding their lifestyles. The program will be conducted through (1) cardiovascular risk screenings for adult and pediatric target groups; (2) educational sessions for at-risk participants conducted by a health educator and a nutritionist; (3) one-to-one counseling and group education sessions; (4) physical activity sessions offered onsite and in other locations; and (5) pamphlets and flyers about local referral agencies, distributed on a regular basis. Target groups include 450 adult Coconino County employees, 500 2- to 5-year-old children, and 300 mothers. Evaluation will assess both reduction in risk factors and behavior changes. Health statistics will be compiled through either the existing nutrition surveillance system or county data collection. A chi-square analysis of risk factor reduction and lifestyle change, telephone surveys, and questionnaires will also be utilized.

81-0459

A Prevention Center Within the Glendale Union High School District to Prevent and-or Reduce Incidents of Teen-Aged Abuse of Tobacco-Based and Alcoholic Substances.

Thunderbird High School-Glendale Union High School District 205, Glendale, AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Glendale Union High School District program is designed to (1) develop a full-time smoking and drinking prevention program at Thunderbird High School open to the surrounding community and to students 13-19 years old, (2) develop information dissemination programs in the district's schools and in the community, (3) develop full-time intervention programs and referral services, (4) reduce first-time use of alcohol or tobacco among students to less than 6 percent, (5) reduce abuse or addiction by 50 percent among students, (6) reduce truancy and increase achievement, (7) promote a higher measurable awareness of the dangers of drinking and smoking, and (8) generate community interest. The program will offer orientation sessions, peer education, individual and group counseling, outside involvement of community members in planning, values-clarification and decision-making exercises, parenting seminars, teacher inservice training, ref-

erral services and crisis intervention, a credit course, a resource library, literature dissemination, a monthly newsletter, and information dissemination to the entire community about prevention and program services. The target group is the entire Glendale community, primarily high school students, junior high school students, and their parents and teachers. Surveys, polls, questionnaires, and testing data will be used to determine levels of awareness about harmful substances, levels of awareness about the prevention center and its functions, attitudinal dimensions with regard to personal use of tobacco and alcoholic substances, and outlook on the substance abuse problem.

81P-0460

Project Health Promotion.

Gila River Indian Community, Sacaton, AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

Project Health Promotion is designed to affect all members of the Gila River Indian Community by (1) providing educational opportunities to 9- to 15-year-old children for goal setting, decision making, and values clarification to allow them to make informed decisions about drinking and smoking; (2) providing physical fitness programs for 18- to 24-year-old youth to reduce the stresses and behaviors leading to heavy drinking; (3) reducing by 2 percent the proportion of 12- to 18-year-old youths who smoke; (4) establishing an ongoing reservation-wide physical fitness program for children, teenagers, young adults, and the elderly, and teaching them self-monitoring techniques; (5) reducing participants' body weights; (6) motivating 50 percent of tribal employees to join the physical fitness program by 1981; (7) reducing fasting blood sugar levels of diabetics participating in the program by 15 percent by 1981; (8) reducing the proportion of 18- to 24-year-old frequent heavy drinkers by 5 percent by 1985; (9) decreasing recidivism of 15- to 24-year-olds in the residential treatment centers by 50 percent by 1985; and (10) gradually transferring operation of the health education and physical fitness program to the tribal recreation department. The physical fitness component will offer exercise classes at a large gymnasium in Sacaton. Motivational methods will be employed to encourage participation, and participants will be evaluated regularly. The program will also feature a health resource center, wellness classes, and individual counseling. An alcohol and smoking prevention component will feature curricula for grades 3-5 and 7, peer counseling for truants, and an exercise program for 15- to 24-year-old residents of the treatment centers. The target group consists of 585 tribal employees and their families, a total of 1,281, with special emphasis on obese diabetics, treatment center residents under age 24, and adolescents. Evaluation methods will include health assessment questionnaires, serial objective measurements on individuals, and records review for changes in recidivism.

81P-0461

Project West Pinal.

University of Arizona, Tucson, AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

Project West Pinal is designed to (1) initiate and deliver a strong community-based health education-risk reduction alcohol and smoking program to the target population, which consists of 10- to 14-year-olds in central west Pinal County; (2) coordinate the efforts of relevant public, private, and voluntary agencies to reduce the risks of premature death and disability associated with smoking, alcohol consumption, diet, hypertension, stress, and other risk behaviors; and (3) establish a surveillance system for risk factors related to preventable health conditions and chronic diseases. The program will be conducted through (1) a publicity campaign in the first year; (2) a survey to collect community data for planning health fairs; (3) a mass media campaign to increase awareness about lifestyle risks; (4) workshops; (5) health fairs; (6) the planned development of a lifestyle resource center; and (7) a school curriculum emphasizing wellness, the dangers of smoking and drinking, values clarification, decision making, and assertiveness. Each component will be evaluated by using pre- and postintervention surveys.

81P-0462

Reduction--Smoking and Alcohol Grant, Values Awareness Program.

Southeastern Arizona Behavioral Health Services, Inc., AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Values Awareness Program is designed to (1) reduce the risk of premature death and disability among the target population (the 3,873 students in grades 6-8 attending 4 schools in Cochise, Graham, Greenlee, and Santa Cruz Counties) associated with smoking and drinking; (2) reduce by 8 percent the incidence of smoking; (3) reduce alcohol abuse by 5 percent; (4) increase self-awareness among 30 percent of target-area youth; (5) increase educators' and guidance counselors' skills in providing health promotion information and alternative activities to tobacco and alcohol use, through emphasis on personal choice behaviors, by reaching 10 percent of these participants in an inservice training seminar; and (6) develop and initiate a peer counseling program in 50 percent of area schools. The program will be conducted through (1) an interactive skill and personal-growth development program dealing with values awareness, self-concept, peer pressure, decision-making, and problem-solving skills, in seven junior high schools; (2) a training seminar for educators and guidance counselors on teacher-effectiveness training, values facilitation, and tobacco and alcohol education; (3) a manual for educators and guidance counselors; and (4) a peer counseling program. Evaluation will be conducted through before-and-after surveys of the target group, subjective assessment by the target group, and assessment by participating educators and guidance counselors.

81P-0463

Smoking and Alcohol Abuse Project.

Colorado River Indian Tribes, AZ

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Smoking and Alcohol Abuse Project is designed to (1) deter target population individuals (those on the Colorado River Indian Tribes reservation 24 years old and under) from smoking and drinking; (2) establish base-line data for the target population; (3) screen 100 percent of the target group for risk factors and make appropriate referrals; (4) supplement existing programs with needed resources in outreach, education, prevention, and peer leader intervention; (5) expose individuals to various intervention methods, including alcohol and smoking education sessions, life planning groups, alcohol treatment, mental health counseling, and preventive activities; (6) help the target population deal with social pressure and develop positive behavioral styles; (7) help the target population establish stronger identities as Indians; (8) decrease the incidence of alcohol problems and facilitate treatment, and lower the number of alcohol-related accidents; (9) decrease the number of occasional and regular smokers; (10) reduce the alcoholism death rate to 10 per 100,000; and (11) increase knowledge of hazards associated with alcohol and tobacco use. The program will be conducted through (1) compiling during screening information about alcohol and smoking habits; (2) conducting outreach programs and health education interventions; (3) establishing risk prevalence through evaluation of screening data and making appropriate referrals; (4) conducting life planning groups to introduce problem-solving, decision-making, coping, and communication skills; (5) using peer leaders, a prevention specialist, and referrals to mental health and alcohol programs; (6) assigning individuals to groups with others who are at the same risk level; (7) conducting programs and providing materials on the Indian's role in society; (8) implementing outreach and intervention activities; (9) using life planning groups to decrease peer pressure to drink; (10) providing health education on benefits of decreasing the number of cigarettes smoked; (11) aiming prevention activities at the younger population; and (12) using health hazard appraisal and screening forms. Participants will be monitored from initial screening entry and at 6-month intervals thereafter.

ARKANSAS

81P-0464

Health Education-Risk Reduction (HERR) Grant Project, Arkansas.

Smith, D.

Arkansas Department of Health, Division of Health Education Services 4815 West Markham, Little Rock, AR 72201

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Arkansas was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an

organized approach to risk reduction. The inventory of health agencies and volunteer groups providing HERR activities will be updated. A pamphlet describing the HERR project will be distributed to the general public. Plans to stimulate active assistance from voluntary health agencies, professional organizations, and other groups offering HERR activities will be developed. Financial and other support will be provided to Berkeley projects within the State and Arkansas Conference on Lifestyle Modification. CDC's Common Data Items will be provided to groups identified as collecting data. Local intervention groups will be required to collect and report data. Inventory of collection systems for morbidity and mortality data of chronic disease will be updated. Additional morbidity and mortality data that should be added to existing collection systems will be specified. Key groups within communities will be identified. Discussions between key groups within a given community will be initiated.

CALIFORNIA

81P-0465
Health Education-Risk Reduction (HERR) Grant Project, California.
Mozar, H. N.
California Department of Health Services, Chronic Disease Control Section, 714 'P' Street, Room 499, Sacramento, CA 95814
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in California was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. Beginning FY 1981, to be completed by 1985, all 58 counties will be inventoried for health education risk reduction programs and services at the rate of 12 per year. The process for identifying the first 12 counties to inventory is as follows: recruit student intern to assist in inventory; identify core group of interested counties by letters and contact with 14 HSA's in State, County Health Officers and Conference of Health Educators; enlist two communities per county taking an organized approach to risk reduction to coordinate the inventory in their respective counties; and counties will name a lead agency as local coordinator. By March 1, the HERR staff will develop the basic survey tool, with test and review by April 1981; the survey will be completed by July 1981. The initial 12 counties surveyed will receive survey report results by September 15, 1981. Surveys will be updated annually with new, updated, or expanded inventories available September 15 each year. By September 1, 1981, an initial list of persons expressing interest and need for HERR information will be notified of the inventory's availability. Interest in the inventory will be stimulated through meetings with the HERR Advisory Committee, California Conference of Local Health Officers (CCLHO) and California Conference of Local Health Department Nutritionists (CCLHDN), contacts with existing known programs, and 14 HSA's. Through a newsletter to agencies on the mailing list, a statewide press release, and the DHS, Office of External Affairs, information will be shared with other State Advisory Committees. The HERR Advisory Committee, of which seven members represent other State agencies most of whom are involved directly or indirectly with program activities, will meet at least semiannually and at a maximum quarterly to review program goals, objectives, and activities and to advise on areas of interest relating to HERR program activities. Their involvement will be stimulated through quarterly reports from HERR staff and through task forces and committees. The HERR program coordinator will provide linkage to other health program activities by being on the Health Education Council, consulting with, planning, and developing a statewide media campaign. At least five members of the Advisory Council will represent local, voluntary, private, and public agencies. Evidence of relationships will be demonstrated by site visits, participants in proposal review committees, and in planning an annual HERR conference. By February 1981 a subcommittee of Advisory Committee members from voluntary-private agencies who address risk factors will meet and confer to develop one or two common objectives to be addressed for the coming year by the State and each participating agency. By September 1981 recommended methods to determine the prevalence of risk factors will be established through discussions with State hypertension, aging, diabetes, and human population laboratory programs and voluntary agencies and departments regarding current methods for determining prevalence and the possibility of compatible or uniform systems. A subcommittee of the HERR Advisory Committee will review types of data needed, how to collect the data, and appropriate survey tools; survey tools will be matched to CDC's recommended Common Data Items. Also by September 1981 staff will provide technical assistance to at least three counties in determining prevalence of risk factors in the forms of training programs and a risk factor prevalence tool. By November 1980 the State will identify those chronic diseases impacted by smoking,

alcohol use, obesity, stress, hypertension, and other lifestyle-related activities; by December 1980 sources of available data will be identified; by June a miminal data set will be determined; and by August necessary agreements to secure data will have been entered into. By September 1981 the first stage of the HERR surveillance system will be in place. By August 1981 areas of chronic disease surveillance needing improvement will be identified, and a framework to improve surveillance will be adopted. By November 1, 1980, at least 75 agencies or organizations requesting information relating to HERR activities will receive information regarding characteristics which define a community as undertaking "an organized approach to risk reduction." Each of the 21 proposals to "deter children and youths from smoking and alcohol use," plus the 6 continuing intervention projects will be informed, in time for a planning process to be initiated, that proposals from agencies and organizations from within communities undertaking "an organized approach" will receive priority funding in 1981. By March 1981 State-level HERR Program staff will work with at least three organizations or agencies interested in undertaking the OARR in their community. By June 1, 1981, the State HERR program staff will document and identify communities who are committed to undertaking the OARR. By September 1981 the State HERR Program staff will provide technical assistance for the establishment, maintenance, and improvement of the OARR being undertaken by communities committed to this concept-design.

81P-0466
Adolescent Smoking and Drinking Risk Reduction: Contra Costa County.
Contra Costa County Department of Health Services, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Adolescent Smoking and Drinking Risk Reduction program is designed to (1) reduce the incidence of smoking and alcohol use by 50 percent in the target group (400 randomly selected high school students), by 25 percent in an extended population of peers, and by 25 percent among school personnel and the parents of target group teenagers within 3 years; (2) organize a cadre of student peer leaders to promote lifestyle change; (3) stimulate improved health behavior in school staff and parents, who serve as adult role models; and (4) develop a community network to reduce drinking and smoking risks. To accomplish these goals, the program will (1) select participants and administer a "lifestyle survey" to determine the incidence of smoking and drinking; (2) obtain base-line information on the number of alcohol-related arrests of juveniles and the number of alcohol-related auto and motorbike accidents; (3) establish an advisory committee of students and faculty, recruit and train four students per school to administer the survey, establish monthly "Monday morning assessments" of smoking and drinking activities over the prior weekend, and establish "lifestyle clubs"; (4) work with teachers to design and implement health presentations, and assist in outreach to parents of club members and other adults in the community; (5) provide, through the clubs, counseling; teaching; and activities such as health fairs, teen risk reduction assessments, and a campus lifestyle survey; (6) administer health risk assessments to 50 percent of school personnel and parents, and have half those who take assessments make contracts to make at least one recommended behavior change within 6 months; (7) provide participants with counseling about the results of the health risk assessments and support health behavior changes (by creating such resources as smoking cessation clinics, if necessary); (8) approach community groups and agencies to describe the project; and (9) compile a directory of local resources and risk reduction facilities. Evaluation will be conducted through (1) a pretest for base-line data, (2) a followup test 3 years later, (3) collection of the requisite number of health assessments and contract statements, (4) assessment of clubs through membership, and (5) questionnaires regarding contracted behavior changes.

81P-0467
Alameda County Health Education-Risk Reduction Project.
Alameda County Health Care Services Agency, Public Health Service, 499 5th Street, Oakland, CA 94607
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Alameda County Health Education-Risk Reduction (HERR) Project is designed to educate selected staff members of the Alameda County Public Health Service (ACPHS) in the basic theory and practice of health education and risk reduction. These staff members, using consultants as necessary, will develop an instructional protocol and train the rest of the ACPHS staff. After training, all Alameda County field and clinic personnel will be able to instruct clients in a basic HERR program. A methodology will be developed for implementing the program in ACPHS field and clinic services. The program will also be integrated into the ACPHS program. All students in the Alameda County school system will be exposed to risk reduction concepts by the end of the fifth project year. At least 25 percent will enter some type of HERR program or demonstrate their understanding of the effects

of such a program. Evaluation tools will be developed and refined, and a committee will be established to coordinate the efforts of the ACPHS with those of local voluntary organizations. The project coordinator will be largely responsible for developing the curriculum and selecting the most appropriate health education methodologies. After completion of this first phase of training, the information system will be modified as necessary before other ACPHS staff members are trained. The first group of staff members who receive this training will develop a detailed protocol for use in training the rest of the ACPHS staff. Staff members will also receive limited training in administering health hazard appraisal tests and in followup counseling of individuals and groups. After the entire ACPHS staff has received the HERR training, intervention instruction and activities will be developed and offered to county residents. Staff members will lecture, provide instructional materials, and actively demonstrate and participate in intervention activities. The ACPHS will help county school systems establish projects to deter children and adolescents from smoking and alcohol abuse. Also, a library containing HERR materials will be developed within the ACPHS. The target population consists of three major groups: (1) staff members of the ACPHS; (2) selected high-risk populations such as children, teenagers, and adults 18 to 35 years old; and (3) health professionals outside the ACPHS. The ACPHS training phase of the program will be evaluated by (1) assessing changes in the health attitudes, beliefs, and practices of participants; (2) administering tests on health knowledge; and (3) assessing adherence to prescribed regimens. The project will be evaluated before the protocol is written. The protocol will be evaluated through actual use with ACPHS clients. Assessment methods will be developed to determine the HERR program's long-term effectiveness.

81P-0468
Health Hazard Appraisal-Risk Reduction Project.
San Francisco Public Health Department, Bureau of Health Promotion and Education, San Francisco, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Hazard Appraisal-Risk Reduction Project of the San Francisco Public Health Department is designed to (1) implement health hazard appraisal (HHA) and risk reduction programs in at least one college setting and train at least two HHA counselors and three risk reduction teachers; (2) implement such programs in at least six businesses or industries; (3) incorporate such programs into the city government's employee health programs; (4) develop assessment components and counseling protocols for the HHA for nutrition and stress; and (5) produce a plan for collecting and analyzing data on morbidity in San Francisco. In the HHA program, the objectives are that 75 percent of the people who take the appraisal and are found to have at least one identified risk will receive counseling and write out a plan for lifestyle change, and 75 percent of these clients will begin at least one program. The risk reduction program has three components: (1) for smoking cessation, the objectives are that 30 percent of the participants will quit smoking, and 50 percent will reduce their smoking by one pack per day; (2) for stress reduction, 50 percent of the clients in the program will feel in control of their stress, and 50 percent will practice a stress reduction exercise every day; and (3) for weight reduction, 50 percent of participants will lose 10 pounds, and 50 percent will feel they eat a more balanced diet. Each component will be evaluated at the end of the program and again 6 months later. The programs will use the health hazard appraisal instrument and offer peer counseling by staff of the selected colleges and businesses, and health department staff will provide health hazard appraisal counseling and risk reduction information. The target group will consist of (1) 2,000 college students, 17 to 21 years old, and (2) employees in business and industry (4,000 in a private sector program and 5,000 in a public sector program). Process evaluation will occur in terms of numbers of persons, colleges, businesses, and city employees participating or being trained in the program. Consultants will be retained to evaluate outcomes.

81P-0469
Health Risk Profile--Risk Reduction Education Program.
Ventura County Health Care Agency, Ventura, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Risk Profile--Risk Reduction Education Program is designed to (1) complete 3,000 health hazard appraisals (HHA's) for special-risk patients and other clients of the Ventura County Health Care Agency; (2) complete 5,000 HHA's for the general population and agency staff; (3) train volunteers to complete HHA's, organize and implement a tracking and foliowup system, and help in the education of patients in group risk reduction sessions; (4) conduct 6 inservice sessions on HHA for at least 60 physicians and the medical care staff of the agency; (5) implement a group education series and individual counseling, with bilingual and bicultural capability, to reach at least 500 people per year who have been identified as being at risk, with at least 60 percent adopting 1 behavior change; and (6) enroll in special bilingual education sessions at

least 60 percent of the parents of identified obese children. To accomplish these tasks, the program will use the HHA; volunteers to conduct bilingual and bicultural group and individual counseling in risk reduction, with emphasis on weight reduction and smoking cessation; and numerous county organizations for risk reduction activities. The target group consists of the agency's (1) low-income and Hispanic clients and patients who are at special risk for the leading causes of death, including overweight pregnant women, children, postpartum patients, hypertensives, diabetics, and any of their family members under 60 years old; (2) community members not previously identified as at risk for any disease; and (3) the agency staff. Process evaluation will be used in terms of number of people who receive an HHA and attend sessions, number of inservice and risk reduction sessions, number of volunteers and agencies participating, and number of people adopting one behavior change within 1 year of program involvement.

81P-0470
Healthy Youth Project.
San Francisco Department of Public Health, Bureau of Health Promotion and Education, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Healthy Youth Project is designed to (1) reduce the health risks of participating teachers by having 80 percent complete a health hazard appraisal and having 50 percent of those who contract to reduce an identified risk do so; (2) reduce the health risks of parents of sixth graders at two junior high schools by having 40 percent of them complete a health hazard appraisal, and having 50 percent of those who contract to reduce an identified risk do so; and (3) prevent the onset of cigarette smoking and alcohol abuse among seventh grade students at one junior high school by providing sixth grade students with skills to resist social pressure. To implement the project, (1) a project trainer will conduct health hazard assessment sessions, counseling, and followups for teachers and parents; (2) the trainer will hire consultants to offer smoking cessation, stress management, weight management, and exercise classes to teachers at school sites; (3) the coordinator will develop questionnaires and collect pre- and postprogram data on all students targeted; (4) the coordinator and advisory committee will modify and adopt curricula developed by the American Health Foundation; (5) the coordinator will present a skills training curriculum to parents of sixth graders; (6) teachers will help recruit peer leaders; (7) the staff will develop a training program for peer leaders, and the trainer will train at least 10 peer leaders; (8) peer leaders will develop teaching materials and conduct classes for the sixth graders; and (9) a drama group will write a script on risk reduction. Sixth graders at a junior high school are the primary target group, with teachers, students, and parents serving as the secondary target groups. Followup on all persons signing risk reduction contracts will be carried out. Pre- and postprogram questionnaire data will be compared.

81P-0471
Life Style, Risk Reduction, And Use of Health Services Project.
Human Population Laboratory (HPL), California Department of Health Services, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Human Population Laboratory (HPL) has conducted research on the relationship between health and lifestyle since 1959. Findings accumulated over 15 years have led to the formulation of a model of health, conceived as general resistance to illness, which emphasizes three broad classes of behavioral risk factors: lifestyle, stress, and social support. To develop the potential of this model for use as a tool in formulating health policy, the project will (1) increase the capability of valid prediction of health outcomes by making improvements in the explanatory model of general susceptibility and resistance to disease and certainty about the consequences of modifying specific risk factors, (2) estimate the effects of behavioral risk factors on the use of health services, and (3) identify sources of stability and change in behavioral risk factors for general susceptibility to illness. To accomplish these tasks, the project will use (1) multivariant analysis of mortality data from longitudinal files on members of the HPL cohort (data since 1959) to increase the capability of predicting health outcomes for individuals, (2) data analysis to support the construction and validation of life-event indices for measuring stress, (3) a survey via a modified 1974 questionnaire to determine the effect of lifestyle on the use of health services. The target group will consist of 7,000 residents of Alameda County. Evaluation will employ tests of significant differences and multivariant analysis.

81P-0472
Peer Education Project.
County of Riverside Bureau of Health Education, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Peer Education Project is designed to (1) train 200 students in 10 classes in 4 high schools as peer educators; (2) provide presentations by peer educators to 3,000 elementary and secondary school students; (3) provide an orientation session regarding the peer education program to 50 percent of the faculty of the 4 high schools; (4) provide speakers to community-based groups; (5) train 200 peer educators in making presentations, assessing their presentations, and working effectively in group situations; (6) effect specific policy changes in each of the 4 high schools aimed at reducing risk factors associated with alcohol and smoking problems; (7) increase knowledge of smoking and alcohol education by 50 percent in PTA groups; (8) effect a 60-70 percent increase in awareness of risk factors associated with alcohol and smoking in peer educators completing the program; (9) effect a 20-25 percent reduction in both the number of students using tobacco and alcohol frequently and the amount of tobacco and alcohol used in each of the 4 schools by the end of the second year of the program; and (10) present 40-50 productions by a performing arts caravan. In conducting the program, (1) selected sophomores and juniors take a health education class focusing on risk factors; (2) pairs of students respond to requests for speaking engagements made by faculty members; (3) faculty orientation sessions are conducted by a coordinator and health educators, and the faculty complete assessment questionnaires; (4) peer educators give presentations to community-based groups; (5) videotape recorders are used extensively to train peer educators; (6) health educators assess existing school policies and procedures and develop improvements regarding reduction of risk factors; (7) support groups of interested parents are organized to promote peer education; (8) pre- and postassessment questionnaires are given to test awareness of risk factors among peer educators; (9) a statistician analyzes participant assessments and other data; and (10) alcohol- and smoking-related productions are given by the performing arts caravan, followed by discussions led by peer educators. The target group consists of students in grades 10-12 in four high schools. Evaluation will be the responsibility of the project coordinator, with specific functions being carried out by the statistician. Three questionnaires will provide the bulk of evaluative data: a student pre- and postquestionnaire on risk factor knowledge, a teacher health practices survey, and a parent health practices survey. Additional evaluation data will come from forms filled out by participants after each program activity. Data will be tabulated and compiled on a quarterly basis.

81P-0473
Project Cope.
Shasta County Department of Health Services, Redding, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Project Cope is designed to (1) develop knowledge and attitudes about alcohol, tobacco, and marijuana in the target group (high-risk students in grades 4-9) in such a way as to reduce use of the substances; (2) educate parents about alcohol use and smoking reduction; (3) reach native American organizations, surrounding counties, and private schools; (4) evaluate program activities, and finalize evaluation instruments; and (5) finalize curricula for the second year. The program will be conducted through (1) demonstration of affective education and substance use prevention curricula to fifty fourth-eighth grade classrooms; (2) weekly exercises on respect for self and others, school life, substance use and nutrition, and emotional maturity; (3) teacher training on the use of risk reduction student activities; (4) intervention in six ninth grade classrooms, with eight risk reduction exercises; (5) monthly 1.5 hour classes for parents of participating students; (6) a pilot survey of 1,000 Shasta County students to determine prevalence of alcohol, tobacco, and marijuana use; and (7) consultations with 5 native American councils and dissemination of intervention strategies. For evaluation, teachers will complete feedback forms; outcomes will be measured through pre- and posttests. Also, school authority reports, school attendance records, police reports, probation reports, and health department reports will be analyzed. A survey of surrounding businesses will be conducted to determine youths' attempts to purchase tobacco and alcohol.

81P-0474
A Project to Deter Children and Adolescents From Smoking and Alcohol Abuse.
Drew Medical-Dental Center, Inc., CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Project to Deter Children and Adolescents From Smoking and Alcohol Abuse is designed to affect students' attitudes and behavior in regard to adult-sanctioned recreational substances by promoting self-understanding and responsible decision making. To accomplish this goal, the program will (1) incorporate information designed to deter adolescents from smoking and alcohol use into existing programs at Drew Medical-Dental Center, which

will be attended by 275 adolescents 10-19 years old; (2) provide an informational unit on cancer, smoking, and cardiovascular disease to 1,349 students in grades 4-8 in 2 of the community's 5 schools; (3) make a presentation on alcohol abuse to all sixth and seventh grade classes in the community's 5 schools, and offer 1 indepth course to sixth and seventh graders in 1 school. The target group will consist of approximately 3,100 children and adolescents (69 percent black and 21 percent Hispanic) in grades K-8, the majority of whom are of low socioeconomic status. For evaluation, data will be collected from pretests and from essays written by the students. Additional data will include the number of students participating; quality and types of exhibits; and comments from students, staff, and parents. Data on adolescents will be stored via computer for comparison in subsequent years. Cigarette smoking will be evaluated in terms of cessation or never starting. Alcohol abuse will be evaluated in terms of reduction in amount consumed, change in type consumed, encouragement of others not to use alcohol, reduction in alcohol-related crime, change in learning ability, and change in behavior and attitude.

81P-0475
A Smoking and Alcohol Prevention Program for Children and Adolescents in Grades 5, 6, 7, and 8.
San Diego Unified School District and San Diego Interagency Council on Smoking and Health Education, San Diego, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Prevention Program is designed to (1) have project students (about 4,320 in grades 5-8 in 4 junior high schools) demonstrate understanding of the perceived psychosocial benefits of tobacco and alcohol use as compared with the costs and dangers; (2) lower smoking and alcohol use among the project group, as compared with a control group; (3) have project students exhibit fewer smoking and alcohol abuse risk factors, including suspensions, expulsions, dropouts, arrests, drug abuse incidents, and truancies; and (4) have 25 percent of project parents participate in a minimum of two project activities. To accomplish these goals, the program will (1) inventory existing local resources and materials; (2) conduct inservice training to familiarize health teachers with the components of the program, provide them with a review of the dynamics of positive health education, and explore various teaching methodologies; (3) provide similar opportunities to all site staff; (4) conduct a smoking cessation program; (5) design each school's model prevention program to reflect the needs of its student population; (6) administer a survey of smoking and drinking practices; (7) conduct smoking and alcohol presentations in school assemblies; (8) develop a bilingual model of a health program; (9) implement a prevention program using a multimedia approach involving the active participation of students; (10) organize a community involvement program; (11) provide services for referring students and their families to community agencies for counseling; (12) develop a program of parent involvement; and (13) evaluate the program. Evaluation will consist of pre- and posttesting, an attitudinal inventory, a review of inservice activities and community activities, and a review of parent participation records.

81P-0476
Smoking Withdrawal Action Project (SWAP).
Monterey County Health Department, Monterey, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Smoking Withdrawal Action Project (SWAP) is designed to (1) provide free smoking cessation clinics, which will attempt to reduce the smoking rate by 50 percent of 500 to 900 smokers who attend; (2) establish an interagency network, entitled "Coordinating Council for Community Health Promotion"; (3) develop specific programs for prenatal patients, oral contraceptive users, parents, and teachers; (4) establish a health promotion center in the Monterey County Health Department office; (5) conduct an antismoking public awareness campaign; (6) enable industry, labor unions, hospitals, community organizations, recreational centers, alcoholism service providers, and other interested groups to offer smoking cessation clinics in their own settings; (7) support clean indoor air in public buildings; (8) develop and implement short-term and long-term evaluation systems to determine the effectiveness of the clinic model, teaching and maintenance methods, instructor effectiveness, sustained behavior change by participants, and overall impact on community awareness and attitudes; (9) explore continuation of the program on a reduced-funding, increased-fee basis, with the option to seek community donations; (10) explore the feasibility of instituting health promotion programs to address nutrition, exercise, weight control, and tension related to heart disease and cancer; and (11) coordinate and mobilize community resources to reduce the incidence and prevalence of smoking, alcohol abuse, obesity, stress, hypertension, and other precursors of preventable chronic diseases. The program will utilize a 6-week smoking education program designed in collaboration with the Stanford Heart Disease Prevention Project (SHDPP). The program will also have leaders in industry,

labor, human service, and recreation, who have been trained by the SHDPP, conduct smoking cessation clinics in their own settings. The target group consists of the population of Monterey County, particularly women of childbearing age, patients under medical treatment for chronic disease, health professionals, and smokers who are ready to quit. The impact of the program should be reflected in the medical surveys conducted on randomly selected volunteers (about 1000) by the SHDPP. Various surveys will be conducted to evaluate the extent of participants' smoking abstinence resulting from the program, the number of businesses who have established programs in their own settings, the number of segregated smoking sections in public places, and the number of smoking ordinances enacted.

81P-0477
Sonoma County Health Education-Risk Reduction Program: A Program to Deter Children and Adolescents from Alcohol and Tobacco Use.
Sonoma County Office of Education, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Sonoma County Health Education-Risk Reduction Program is designed to (1) develop an affective and cognitive base to enable young people to make healthy decisions regarding the use of alcohol and tobacco; (2) develop a cadre of trained personnel within the school system capable of adapting and delivering curricula related to reducing the health risks associated with alcohol and tobacco use; (3) strengthen interaction among the schools and community-based agencies, and maximize these interrelationships through coordination of resources; and (4) implement a program that is effective and replicable. In the elementary school component, project staff will design and implement affective and cognitive health curricula as well as train teachers. High school students trained as peer counselors will help teachers present curricula and will act as role models for elementary students. In the junior high school component, 90 seventh-grade students will have weekly group meetings for 1 semester. They will be trained to choose and coordinate their own risk reduction activities. Selected students will then serve on health promotion committees, act as student advisors, and organize and sponsor "outward bound"-type activities. In the high school component, 25-30 students at each high school will be trained for peer counseling. From each group, five or six students will receive additional training and will help conduct health curricula at lower school levels. In the school-community liaison and coordination component, a variety of agencies will be involved in program activities, such as making presentations during peer counselor training, assisting in teacher training, and serving as curriculum resources. A coordinating committee with members from all program components will meet biweekly. The target group includes 8,500 students in 11 schools in Sonoma County. A process evaluation will assess the quantity and quality of service delivery; an outcome evaluation will assess the level of achievement of each of the specific program objectives; and an impact evaluation will ascertain the overall impact of the program on the students, school system, and community agencies involved. Data will be collected through interviews, staff records, participant feedback, and standardized tests, and an evaluation consultant will be utilized.

81P-0478
Training Component for Lifestyle Programs.
San Francisco Department of Health, Bureau of Health Education, San Francisco, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Training Component for Lifestyle Programs will (1) provide at least two workshops to train staff of county health departments in (a) planning and implementing a health hazard appraisal program in a county health department; (b) counseling with appraised clients in risk reduction lifestyle change; and (c) evaluating a risk reduction and lifestyle change program; (2) conduct consultant visits to at least seven county health departments to help staff organize public relations activities, plan programs, and set up individual evaluation efforts for a health hazard appraisal program; (3) develop a handbook on planning and implementing health hazard appraisal programs in a county health department; and (4) provide annual workshops for county health department staff as followups to the initial workshops to discuss new and innovative methods and materials in risk reduction and health hazard appraisal. To carry out these activities, the San Francisco Department of Health, the administering organization, will plan and conduct two 8-hour workshops designed to help the participants (1) develop or improve skills in counseling clients for lifestyle change using health hazard appraisal; (2) develop a system plan for conducting health hazard appraisal within the existing organizational framework of county health departments; (3) examine existing computer and noncomputer appraisal systems; and (4) examine the basic concepts of health hazard appraisal. Workshop activities will include (1) a written needs assessment and interviews to identify present skills and interests in health hazard appraisal; (2) development of materials to assist in the learning and skills

development process; and (3) development of specific objectives based upon perceived needs of participants and trainers. Individual consultation including technical assistance by San Francisco Health Department's Health Hazard Appraisal staff will be provided to health departments wanting to deliver health hazard appraisal programs. This assistance will include (1) examination of the personnel, facilities, and other resources, and target populations; (2) discussion of the outcome objectives; and (3) onsite problem solving and planning, and a written report on recommended directions and activities. A handbook for use by county health departments will be produced to outline steps in planning and conducting a health hazard appraisal program. This handbook will be used as a principal tool in workshops and consultation programs and as an information tool. The target group will consist of California county and State health department staff (nurses, health educators, physicians, and administrators) involved in lifestyle programs. Process evaluation will occur by determining the number of participants, workshops, and consultations, and conformance to schedule. A postworkshop questionnaire will be used with participants to evaluate knowledge gained.

81P-0479
UCLA Tobacco-Alcohol Prevention Program (TAPP).
Center for Health Enhancement, Education and Research, University of California, Los Angeles, CA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The UCLA Tobacco-Alcohol Prevention Program (TAPP) is designed to (1) prevent smoking and alcohol abuse among junior high school students, (2) encourage responsible decision making about alcohol, and (3) develop and evaluate an education and life-skills training curriculum to be implemented in seventh grade health classes. The program will contain 15 lessons, which will include instruction, counseling, and demonstrations on the consequences of smoking cigarettes, the consequences of drinking alcohol, training in decision making, and training in resisting social influences in regard to smoking and alcohol abuse. Materials for the program will be prepared in Spanish and English. Participating teachers will be trained in workshops by the research staff to implement the curriculum. High school peer leaders will be trained as life-skills counselors. Within each school district, participating junior high schools will be randomly assigned to either intervention or control conditions; the program will be implemented in intervention schools during the first and second years. The target group consists of 6,650 junior high and intermediate school students in 9 schools in 4 school districts in Los Angeles and Orange Counties. A project advisory committee will evaluate all aspects of the program. A questionnaire will contain items related to the various objectives. Pre- and posttests will be administered throughout each phase. Self-reports will measure the extent of alcohol and tobacco use among participants.

COLORADO

81P-0480
Health Education-Risk Reduction (HERR) Grant Project, Colorado.
Davis, M.
Colorado Department of Health, Health Promotion and Education Section, 4210 E. 11th Avenue, Denver, CO 80220
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Colorado was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. An initial mail survey of HERR programs was completed in the fall of 1979. To supplement the survey, agencies receiving HERR funds have been contacted and local communities encouraged to conduct their own resource inventories, to be shared through a State clearinghouse. The State will establish a network of 25 people to serve as contacts in their counties and to provide an inventory of local HERR programs and services, and a "talent bank" of 30 people with expertise in developing or evaluating HERR programs will be organized. The State will also develop and evaluate the effectiveness of two publications: (a) "Health Promotion Exchange"--a monthly newsletter on HERR programs and services; and (b) "Seed Catalog"--a listing of outstanding local HERR programs. The Colorado Health Promotion Consortium was established to bring together key individuals and agencies active in health promotion. The consortium members advise, review, and participate in HERR program activities. Staff members of the HERR program have visited program personnel in about 30 agencies to share information and to discuss interagency coopera-

tion. The program is also involved in developing a legislative proposal to seek State funding for school health education programs. The State will maintain and expand the Colorado Health Promotion Consortium and continue developing the HERR program for State employees. The program has established a committee to explore ways to determine the prevalence of risk factors. Survey instruments are being collected for review, and a statewide survey incorporating CDC's recommended Common Data Items will be undertaken. The Colorado Health Promotion Consortium has reviewed the literature and several survey instruments. The Colorado Hypertension Program is already underway and will screen the adult population of Saguache County and also gather data on risk factors related to hypertension. The applicant will develop and refine a risk factor prevalence survey for Colorado. By April 1981 communities participating in the HERR program will complete a survey of the prevalence of risk factors using the Colorado State Model. Initial contact has been made with other State programs that collect morbidity and mortality data on chronic diseases. Additional data sources outside the State Health Department have been identified; a more specific review of these data sources will be completed. Epidemiologists in several States have discussed plans for a chronic disease surveillance system with the assistant director of the State Health Department. The applicant will develop a pilot system to obtain and analyze hospital discharge data from selected hospitals and will develop a system to obtain and analyze physician- and clinic-visit data relating to chronic disease. To increase public awareness of the relationship of lifestyle to health, the HERR program has produced a slide show on risk factors. An HERR program is being developed for State employees. The program will determine methods and models for employment-related programs. These models will be evaluated to determine their replicability for local health departments and private businesses. The State will increase its capacity to provide technical assistance to communities in data collection, evaluation, and identification of smoking and alcohol strategies. The State will establish capacity to conduct a prevalence survey of risk factors, to design and implement appropriate evaluation measures, and to identify and modify strategies to prevent smoking and alcohol abuse among adolescents. The State will develop the capability of all communities with HERR programs to develop appropriate fiscal and activities report procedures. The State will involve additional communities in undertaking organized approaches to risk reduction. These activities will be set up to reflect the State's demographic and ethnic distribution. The State will inform all interested parties of the availability of intervention funds and procedures for developing plans and proposals.

81P-0481

Adolescent Smoking and Alcohol Program--Option Awareness Program.

Community Health Center of Colorado Springs, Inc., Colorado Springs, CO

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Option Awareness Program (OAP) is designed to (1) reduce the incidence of tobacco use among adolescents in El Paso County; (2) reduce the incidence of alcohol use among selected junior high school students; (3) increase self-esteem, coping skills, and decision-making skills of participants; (4) improve the quality of family life for participants; and (5) provide an alternative to suspension from school for students found in possession of alcohol or drugs on school property or at school functions. To accomplish these goals, the program will (1) conduct four 2-hour planning and inservice training sessions for OAP staff and meet with a family therapist consultant, the Advisory Board of Terros of Colorado Springs, and the Adolescent Health Program director; (2) contact officials from at least four school districts to establish policies and procedures concerning the relationship between OAP and each of the districts; (3) have staff attend two meetings of the Pikes Peak Youth Substance Abuse Coalition; (4) contact junior high school principals from nonparticipating schools to collect data and to discuss referral needs of each particular school; (5) give classes for groups of tobacco users and alcohol abusers; (6) schedule four orientation workshops for those involved in referrals; (7) promote community awareness of OAP; (8) present speakers on strategies and issues of tobacco and alcohol abuse to community agencies and organizations; (9) develop a screening and training program for volunteers; (10) complete a policies and procedures manual; (11) administer posttests and collect common data items; and (12) conduct follow-up evaluations. The target group will consist of 660 junior and senior high school students of El Paso County and their families. Pre- and posttests will be administered. Volunteer support will be used extensively in collecting, organizing, and compiling statistics. Self-reports will indicate participants' changes in self-esteem, coping skills, and decision-making skills. Changes in the quality of family life will be documented by the number and perceived quality of contacts among family members.

81P-0482

Alcohol and Smoking Prevention Program for 8-12-Year-Old 4-H Members Utilizing a Community Network

Colorado Cooperative Extension Service, State 4-H Office, Fort Collins, CO

Funding Source: Center for Health Promotion and Educa-

tion (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Alcohol and Smoking Prevention Program is designed to (1) intervene in the development of predisposing factors related to smoking and alcohol use: low self-esteem, lack of decision-making skills, and inadequate sense of self-responsibility; (2) show through pre- and postsurveys that there are measurable increases in self-esteem, decision-making skills, and self-responsibility in youth receiving special training, and test the impact of this training on the tendency to begin smoking or drinking; (3) provide a community environment that enables participants to utilize the skills of self-responsibility and decision making and thus reach maximum self-esteem; (4) provide reinforcing factors that will strengthen the youth in their newly established abilities and their commitment to carry them out; (5) exhibit ways in which community organizations and agencies can combine forces to attack a problem, supplement each other's programs, and "saturate" a community with reinforcing techniques; (6) develop and test an intervention model that can be used by other youth groups; and (7) continue the program for 3 more years. To accomplish these goals, the program will (1) recruit and train personnel; (2) delineate the target audience; (3) select, develop, and administer a survey instrument before and after the program; (4) review resources and approach each audience in a manner especially geared to their needs; (5) offer a special prevention program, which involves training 4-H club leaders and parents; workshops introducing the concepts relating to self-awareness, self-esteem, decision making and peer pressure; a "theatre" workshop for 4-H peer leaders; an indepth workshop for adult 4-H leaders and parents; a group activity followed by another workshop employing role playing; and reinforcing activities such as poster contests; (6) promote community involvement; (7) conduct a year-end survey to evaluate behavior and attitude change; and (8) offer the program in Weld County School District No. 6. The target group will consist of 100 8- to 12-year-olds not enrolled in 4-H, 100 8- to 12-year-olds enrolled in 4-H who will receive the special education program, 100 8- to 12-year-olds enrolled in 4-H who will not receive the special education, and members of 4-H outside this age range. The same samples of 4-H and non-4-H members will be taken from youth in rural school districts that have no formal health education curricula on the effects of alcohol and smoking. For evaluation, pre- and postsurveys will measure changes in self-concept, decision-making abilities, attitudes toward smoking and drinking, and reactions to peer pressure.

81P-0483
Larimer and Mesa Counties Campaign To Reduce Smoking Dependence.
Larimer County Health Department and Mesa County Health Department, Fort Collins, CO, and Denver, CO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Larimer and Mesa Counties Campaign to Reduce Smoking Dependence is designed to (l) reduce the incidence of smoking-related disease and disability in Larimer and Mesa Counties, (2) offer and coordinate smoking cessation programs, (3) provide public education and information on the effects of smoking to health professionals and laymen, (4) encourage the enactment of no-smoking legislation, and (5) provide consultation and assistance to public schools for implementing and evaluating effective smoking education programs. To accomplish these tasks, the program will (l) establish the Larimer and Mesa County Departments of Health as model agencies, placing smoking prevention and smoking control coordinators in the target counties; (2) conduct an educational campaign and smoking cessation clinics for county employees, based on the results of a survey which determined the percentage of smokers, attitudes about smoking in the workplace, and interest in smoking cessation clinics; (3) train representatives from health facilities, industries, community organizations, and voluntary agencies as smoking-cessation clinic facilitators; (4) design an educational component, based on smoking-prevalence data obtained from previous clients of health department programs, to be incorporated into the department's prenatal education program; (5) attempt to ban smoking in schools; and (6) introduce smoking education curricula into the schools, using special coordinators as role models for teachers and providing curriculum guides to one pilot school. Evaluation will be conducted by measuring positive health attitudes, increased knowledge of risk factors associated with smoking, students' decision-making skills, and students' ability to resist persuasion. School personnel and parent advisory groups will collaborate to obtain base-line data on present and future smoking behavior among students in these counties. A teen health survey that will be used in two major school districts is also being developed. School coordinators will assist in the development of a survey tool, and workshops will be developed that provide information on effective smoking education curricula and teaching strategies. Workshops for health personnel will also be presented.

CONNECTICUT

81P-0484
Health Education-Risk Reduction (HERR) Grant Project, Connecticut.
Stoddard, R. R.
Connecticut State Department of Health Services, Smoking Cessation Program, 79 Elm Street, Hartford, CT 06115
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Connecticut was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By September 30, 1981, the State will completely revise the statewide Directory of HERR Resources. Recipients of the 1979-80 inventory will be surveyed regarding its usefulness and information will be updated. Additional organizations will be systematically surveyed concerning their risk reduction activities for this directory, and 1,500 to 2,500 of the revised directories will be printed. Availability of the inventory will be advertised by sending letters to health organizations and professionals and by news releases. The inventories will be distributed to public health nursing agencies, hospitals, local health departments, information services, voluntary health agencies, and other participating agencies. Plans for Fiscal Year 1981 include sharing with other State agencies or departments directly or indirectly involved in HERR the national HERR objectives; to request Connecticut State agencies and departments involved in HERR to respond to these national HERR objectives as they reflect the functions of their agencies; and to communicate to local, voluntary, public, and private organizations which are interested in an organized approach to risk reduction the national health education objectives and State-level activities which reflect risk reduction efforts. Responses will be requested from these local, voluntary, public, and private organizations as they relate to the national objectives. The degree of working relationships initiated or maintained will be documented. A list of committees, task forces, coalitions, councils, etc., currently involved in HERR will be requested from local organizations. All organizations in the State that are currently involved in an organized approach to risk reduction will be enumerated, and common goals and activities will be shared with those organizations. It will be recorded which risk reduction factors were addressed at each meeting. Plans for Fiscal Year 1981 are to investigate and inventory existing sources for risk factor prevalence data in the State and to contract with the Institute for Social Inquiry at the University of Connecticut to collect statewide risk factor information using the CDC's recommended Common Data Items. Local intervention projects will be assisted to conduct surveys using CDC recommended methodology. Plans for Fiscal Year 1981 include expanding the list of smoking-related diseases to include other selected preventable diseases; identifying current reporting systems for chronic disease morbidity and mortality in the State; contracting with appropriate facilities in the State to obtain disease data; analyzing and reporting current mortality figures in a manner that is relevant for HERR programming; analyzing and reporting current morbidity and mortality figures generated through the Connecticut Tumor Registry; analyzing and reporting current hospital admissions data for selected diseases and lifestyle-associated events; and assessing desirability of employing the Traffic Records System for incidence of accident morbidity and mortality. Plans for Fiscal Year 1981 include informing agencies and organizations of the definition and importance of undertaking an organized approach to risk reduction; identifying and documenting those communities in which an organized approach to risk reduction is being undertaken; and providing those communities with a copy of the statewide directory to HERR activities. Assistance (technical and managerial) will be provided to lead to establishment, maintenance, and improvement of community-level projects which show an organized approach to risk reduction. Common objectives between those communities will be coordinated. A statewide nonsmoking maintenance telephone line will be established. The delivery of heart-health education to 35 middle schools in Connecticut will be promoted and improved. The Health Education-Health Promotion Newsletter will be promoted on a statewide basis. Ten HERR workshops will be conducted. HERR activities will be promoted at worksites. In-service training related to risk reduction for selected State employees will be conducted. A regional health promotion campaign will be coordinated with the States of Rhode Island, Massachusetts, and New Hampshire. Local projects will be assisted in collection of risk factor data items and nutritional initiatives in the State will be sponsored.

81P-0485
Health Education-Risk Reduction.
City of Stamford Health Department, CT
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction program is designed to (1) implement a program of school health evaluation focusing on alcohol use by teens beginning to drive, smoking decisions made by preteens, and nutritional habits of elementary schoolchildren; (2) reduce injury due to alcohol-related automobile accidents by 10-15 percent; (3) reduce by 10 percent from the previous year the number of entering sixth graders (in September 1981) who smoke; (4) reduce by 10 percent from the previous year the number of entering sixth graders who are obese; and (5) demonstrate that people can choose health habits through learned concepts of decision making. An alcohol program will develop a life skills workshop to encourage 10th graders to translate drinking and driving knowledge into relevant attitudes and behaviors. The program will involve role playing, group interaction, reinforcement, peer and parent involvement, and use of contracts for behavior change. A smoking education program will develop and administer a pretest to fifth grade classes in eight schools (four experimental, four control) selected at random. The program will involve modified existing resource materials for use in the curriculum; group discussions; lectures; guest speakers; audiovisual materials; independent research; commitments not to smoke for a certain period of time; parent education, involvement, and role modeling; and posttests. A nutrition education program will feature pre- and posttests of fourth grade students, biweekly class sessions covering the role of media in influencing nutrition choices, diet analysis and a weekly diet log, height and weight measures, individual counseling, and exercise. A community-wide survey will collect base-line data on risk factor prevalence. The target group will consist of public school students 10-16 years old (with special emphasis on 750 youths 15-16 years old enrolled in driver's education) for the alcohol component of the program, and 595 preteens (280 fourth graders and 315 fifth graders) for the smoking and nutritional program components. Evaluation will consist of monthly assessments, pre- and posttesting of participants, and use of other instruments developed by an outside consultant.

81P-0486
Middlesex Risk Reduction Project.
Tri-County Alcohol Council, Inc., CT
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Middlesex Risk Reduction Project is designed to (1) produce a data base that will provide a profile of the health status and risk prevalence of the target population (all students in grades 7 and 10 in 3 school districts, all students in grade 5 from 2 school districts (1,500 students altogether), 500 parents and other community members) regarding alcohol abuse and smoking; (2) reduce the prevalence of risk factors involving alcohol and tobacco use, and increase awareness of the effects of drinking and smoking; (3) increase community awareness of the extent and impact of adolescent alcohol consumption and smoking; (4) increase knowledge about the most effective strategies for reducing these risk factors; and (5) promote cooperation among the school systems and local agencies in a community approach to risk reduction. To accomplish these goals, the project will (1) collect data on students and their families; (2) develop curricula for all three grade levels, focusing on increased self-esteem as well as awareness of the effects of alcohol use and smoking, skills for developing responsible decision-making abilities, clarification of values regarding alcohol use and smoking, and exploration of lifestyles that encourage healthy behaviors; (3) provide inservice training to teachers; (4) implement the curriculum, using pre- and posttests as an integral part of the classroom experience; and (5) implement a peer leadership program by recruiting six to eight 10th and 11th graders in each high school for peer training and providing them with an 8-week training program. After completion of this training program, the students will plan and run school-wide drinking and smoking prevention programs, identify and refer high-risk students, and work with younger students at middle or junior high schools. The in-class program will be evaluated on an impact basis using pre- and posttests. Community education activities will be evaluated on a process basis.

81P-0487
A Multi-Dimensional Approach to Health Education-Chronic Disease Risk Reduction Among Fourth and Fifth Grade Children in the Danbury Public Schools: A Quasi-Experimental Research Design.
Danbury Health Department, Danbury, CT
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Multi-Dimensional Approach to Health Education-Chronic Disease Risk Reduction will involve half of all students in grades 4-5 in 11 public schools in an experimental group while the remaining half acts as a control group. This approach is designed to (1) effect a 25 percent increase in positive attitudes toward health-promoting behaviors related to smoking, alcohol, nutrition, and exercise; (2) effect a 25 percent increase in knowledge of chronic disease prevention and health maintenance, especially with regard to smoking, alcohol, nutrition, and exercise; (3) improve food choices by 25 percent; (4) effect a 10 percent increase in the time spent each day in aerobic

exercise; (5) effect 25 percent greater reinforcement of positive health attitudes and behaviors of parents and teachers; (6) effect improved skill in responsible decision making about alcohol, tobacco, food, and physical exercise; (7) engage significant others in the health promotion process; (8) collect common data items to determine the prevalence of chronic disease and risk factors in the community; and (9) collect base-line data on risk factors and behaviors of the target students. Methods include (1) community outreach and involvement: the program will establish a collaborative task force on risk reduction to serve as the steering committee; conduct a survey to determine the prevalence of risk factors in the community and assess the specific needs of teachers, students, parents, and school personnel; and gather base-line data regarding the health behaviors of all fourth and fifth graders; (2) teacher training: the program will provide teachers 35 hours of training on general health principles; (3) curriculum development: the program will review existing curriculum materials and design an appropriate health risk reduction curriculum incorporating a miniscreening component; the discovery method of learning; role playing; peer group discussions; values clarification; multimedia presentations; and experiential skill development; and (4) parent-guardian training: the program will offer four 2-hour parent-training workshops, emphasizing role modeling and modification of personal risk-producing health habits; 22 parent groups; and child care so that parents may attend workshops. Evaluation will consist of (1) formative or continuing evaluation; (2) pre- and posttests to measure changes in knowledge, values, beliefs, attitudes, and behaviors of parents, students, and teachers, and use of a structured observational method to document change in attitudes, values, and beliefs; (3) process evaluation, to record the number of parents attending meetings, teacher utilization of materials, interest generated in the community, and number of students involved in the program; (4) use of common data items; and (5) an annual evaluation of the population for 5 years.

81P-0488
Shoreline Health Education-Risk Reduction Project: Smoking and Alcohol Use Among Youth.
Adolescent Crisis Unit for Treatment and Evaluation (A-CUTE), Hospital of St. Raphael, New Haven, CT
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Shoreline Health Education-Risk Reduction Project is designed to (1) reduce the level of alcohol and tobacco use by 10 percent among the target group (3,000 students in grades 6-9); (2) lower the chances of an initial decision to use these substances; (3) increase awareness of stress reduction as a major factor affecting decisions about alcohol use and smoking; (4) experiment with different approaches to stress and risk reduction educational and training activities, to gather comparative data on the most effective techniques; and (5) bring together 2 regional agencies, 4 municipal agencies, and 4 school systems in a combined risk reduction effort. The program will involve (1) training faculty and nurses to run risk reduction workshops; (2) training peer counselors and implementing a peer counseling program; (3) providing stress reduction workshops to students and parents in each of four towns, using didactic presentations, films, discussions, role playing, self-inventory, observation, feedback, relaxation exercises, assertiveness training, physical conditioning, communications skills, and self-monitoring techniques; (4) conducting pretests, posttests, and followup; (5) holding a community symposium in each town to review the work of the project and generate ideas for risk reduction activities in the future; and (7) producing a training manual summarizing and integrating alcohol and smoking risk reduction. Evaluation will consist of (1) process evaluation, i.e., documenting efforts to achieve program objectives by recording all meetings, training sessions, and workshops; (2) outcome evaluation, i.e., conducting pre- and posttests and followup to measure reduction in student alcohol use and smoking, improvement in attitudes about substance abuse, and improvement in coping strategies for stress reduction; and (3) internal comparison (planned variation evaluation), i.e., analyzing the differential impact of various program models.

81P-0489
Smoking Registry.
Connecticut State Department of Health, Preventable Diseases Division, 79 Elm Street, Hartford, CT 06115
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Smoking Registry will provide data on the prevalence of smoking and related disease among the Connecticut population. The Registry will (1) use the existing Connecticut High Blood Pressure Registry as a model; (2) begin operation after a contract has been awarded to the appropriate groups, agencies, or individuals by the Smoking Cessation Program; (3) work in conjunction with the Connecticut High Blood Pressure (CHBP) Program, complement it, and jointly screen and track people with risk factors of smoking and hypertension; (4) perform screening identical to current hypertension screening and include industrial screening; (5) act as a surveillance model for identifying smoking-related diseases and lifestyle fac-

tors, with base-line data to be obtained on disease prevalence, height, weight, blood pressure, nutrition, cholesterol level, and exercise; (6) obtain specific data concerning smoking habits and cessation efforts; and (7) provide computerized tracking and followup services. The program is directed toward all Connecticut residents. Evaluation will be performed by determining the degree to which the Registry is used.

DELAWARE

81P-0490
Health Education-Risk Reduction (HERR) Grant Project, Delaware.
Breukelman, F.
Department of Health and Social Services, Division of Public Health, Federal and Water Streets, Dover, DE 19901
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Delaware was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By July 31, 1981, the State will have a card file inventory, cross-indexed by county and risk factors, of all HERR programs in the State. By September 30, 1981, the State will publish at least two pamphlets devoted to a specific risk factor, utilizing the inventory to direct the public to available resources. By September 30, 1981, the Delaware HERR staff will have a system for annually duplicating the inventory of HERR programs and services. The State will have an advisory council by March 30, 1981, to offer guidance to the project staff and cooperating agencies and to review intervention proposals received. By September 30, 1981, at least one seminar will be held in each county to inform local agencies about program goals. By September 30, 1981, agencies and organizations involved in risk reduction programs and services will be informed about the State program, its goals, and services. By September 30, 1981, the State will identify agencies with experience in risk factor prevalence surveys and will collect existing data. The State will provide technical assistance regarding risk factor prevalence surveys and health education methods to community, State, and volunteer organizations. Training in survey techniques, models, and evaluation will be provided for the HERR program staff and the Office of Public Education. The State will also develop a system for collecting survey data generated by community agencies for use in planning and reporting to the national program. By June 30, 1981, the State, in cooperation with the Department of Public Instruction, will develop guidelines regarding clearances and endorsements for risk factor prevalence surveys in schools. The State will identify existing sources of chronic disease morbidity and mortality for the purpose of improving surveillance. By May 1981 chronic disease mortality data for Delaware will be improved as evidenced by availability of mortality data by specific chronic disease, age, sex, and race. By September 30, 1981, liaison will be developed with other State agencies involved in collecting morbidity data on chronic diseases. By May 1981 the State will have a central file of surveys relating to chronic disease morbidity and risk factors. By September 30, 1981, the State will develop a system for an annual review and report on studies collected by the program. The State will assist communities to undertake an organized approach to risk reduction. By March 1981 agencies involved in risk reduction activities will be notified of services of the State program for organizing and assisting community agencies. By September 30, 1981, the State will have a system of responding to requests for community organization and risk factor prevalence study assistance from community agencies. During February and March 1981, public seminars will be conducted by the program staff and members of the Advisory Committee to promote organized approaches to risk reduction in each county. By September 30, 1981, the State will identify at least three communities in Delaware taking an organized approach to HERR activities. By May 1981 at least one intervention proposal will be stimulated for a high risk minority population. By January 1981 the Delaware HERR program will set guidelines for monitoring any agencies which receive intervention proposal grants. By September 30, 1981, the applicant will have conducted at least two on-site visits with intervention projects to evaluate and provide assistance, and the State will have a system for quarterly evaluation by the Director of the Office of Public Education.

DISTRICT OF COLUMBIA

81P-0491
Health Education-Risk Reduction (HERR) Grant Project, Washington, D.C..
Buford, J. A.
District of Columbia Department of Human Services, Commission of Public Health, 1875 Connecticut Avenue, Washington, DC 20009
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Washington, D.C., was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. To inventory existing HERR programs and services, decisions will be made by December 31, 1980, concerning the utilization of a directory and for an agreed upon definition of HERR services or programs. By January 31, 1981, a list of agencies which provide HERR services and programs will be developed, how the data will be inventoried will be decided, and the format and methodology which will be used to collect and compile data from D.C. agencies will be prepared. By March 31, 1981, the data will be collected, compiled, and developed into a directory, and the directory will be reproduced and mailed to HERR agencies. By September 30, 1981, the directory will have been updated. The District of Columbia is unique in its position; the Commission of Public Health serves as State health agency as well as providing local health services. An Inter-Agency Committee on HERR is being organized. Agencies to be involved include the D.C. Public Schools, DHS Alcohol and Drug Abuse Services Administration, DHS Research and Statistics Division, D.C. Cancer Society, D.C. Lung Association, National Capital Heart Association, Georgetown University, George Washington University, Howard University, Catholic University, Center City Community Corporation, Boys' Clubs of Greater Washington, United Planning Organization, Big Brothers, Potomac Naturpathic Medical Institute, Columbia Heights Youth Club, Washington Area Council on Alcoholism and Drug Abuse, Inc., Student National Medical Association, Inc., D.C. Cooperative Extension Service, and People United to Save Humanity. During FY 1981 methods will be established to determine the prevalence of risk factors. By February 27, 1981, representatives from the DHS Research and Statistics Division, Georgetown University, George Washington University, Howard University, and Catholic University will be invited to a meeting to discuss methods to determine prevalence of risk factors, using the Common Data Items recommended by the CDC. By March 31, 1981, local agencies will be invited to a meeting to discuss risk factor data available and decide upon the risk reduction data needed. By April 30, 1981, a decision will be made concerning the methods to be used in collecting data concerning the prevention of risk factors. By May 29, 1981, a contract will be made with an agency to provide consultation aid in developing a plan to collect data to determine the prevalence of risk factors. Existing sources of data relating to chronic disease morbidity and mortality and the prevalence of risk factors will be identified. By October 31, 1981, staff will meet with representatives from the DHS Research and Statistics Division to determine the availability of chronic disease morbidity and mortality data. By December 30, 1980, staff will meet with representatives from D.C. health agencies to determine the morbidity and mortality data available and the prevalence of risk factors currently known and how this information can be compiled and presented. By May 29, 1981, it will be decided which chronic disease morbidity and mortality data and risk factors are needed. Meetings will be held with representatives from governmental and volunteer health agencies to develop a plan for securing the data. By September 30, 1981, a date for a reevaluation will be scheduled. To maintain working relationships with State and local agencies, by December 31, 1980, a definition of working relationships will be agreed upon. By January 31, 1981, program goals, objectives, and activities will be discussed with other State agency staff involved in program functions. At a minimum, these agencies include the D.C. Public Schools, DHS Alcohol and Drug Abuse Services Administration, DHS Research and Statistics Division, D.C. Society, D.C. Lung Association, the National Heart Association, Georgetown University, George Washington University, Howard University, and Catholic University. By March 31, 1981, the project staff will meet with agency executives and staff involved in HERR activities to discuss the HERR project and encourage involvement. By April 30, 1981, State agencies involved in program functions will be invited to a meeting to discuss project goals and activities. By May 31, 1981, public and private agencies carrying out or interested in risk reduction activities will be invited to a meeting to discuss program goals, objectives, and activities. By September 30, 1981, working relationships will be documented.

81P-0492
Washington Area Council on Alcoholism and Drug Abuse (WACADA) Alcohol-Smoking Risk Reduction Project: A Pilot Prevention Program for Minority and Handicapped School Students.
District of Columbia Department of Human Services, Preventive Health Services Administration, DC
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Alcohol-Smoking Risk Reduction Project is designed to (1) reduce alcohol- and smoking-related diseases by 10 percent among the 68,000 minority and handicapped children attending 3 experimental schools, particularly grades K-6; (2) develop a curriculum pertaining to cigarette smoking and alcohol use; (3) develop a program evaluation component utilizing "Here's Looking at You"; (4) train student teachers to deliver the curriculum; (5) train school guidance personnel in family problems associated with alcohol abuse; (6) make training and the curriculum available to other schools; (7) have the curriculum permanently incorporated into the 3 experimental schools; (8) raise consciousness concerning smoking and drinking choices among parents, teachers, students, and counselors; (9) mobilize adult resources in schools and the community concerning the wide range of illnesses related to smoking and alcohol use; and (10) devise a program tailored to the special needs of minority and handicapped persons. Methods for the first of the project's 5 years include (1) establishing an advisory council of youths from the three schools and an adult citizens advisory council; (2) supporting community organizations enlisted in curriculum design; (3) using an alcohol and smoking curriculum adapted to the needs of minority and aurally handicapped students; (4) training teachers and student teachers; (5) training school counselors and social workers; (6) organizing and mobilizing new and existing parent support groups; (7) establishing a health education network in the private sector as a resource for parent support groups; (8) offering two 2-day summer camp sessions, with activities related to smoking and alcohol education; and (9) conducting a longitudinal study of students at experimental schools. The program will conduct process, impact, and outcome evaluation.

FLORIDA

81P-0493
Health Education-Risk Reduction (HERR) Grant Project, Florida.
Mathews, H. P.
Department of Health and Rehabilitative Services, Health Program Office, 1323 Winewood Boulevard, Tallahassee, FL 32301
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Florida was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The HERR State program will develop a computerized and retrievable inventory of existing HERR programs and services for State-level organizations, intervention projects, and selected Florida counties. Data will be retrievable by county, geographical area, and program subject. The inventory will be distributed in booklet form, through the county health units, to organizations listed in the inventory, ongoing intervention projects, the HERR Advisory Committee, State agencies, and those requesting the booklet. The initiation of the State HERR program, its goals and objectives, and the potential for funding community intervention proposals will be announced through official State channels and by three workshops held around the State. The State HERR program will become an active member of the Health Program Office, Chronic Disease Strategy Committee. Working relationships will be developed with various State agencies in order to develop a statewide chronic disease strategy. The HERR will also provide technical assistance to the Florida Public Health Association for the development of professional education in the areas of health promotion and risk reduction. An HERR Advisory Committee will provide technical assistance to programs, develop policy and future direction, and, whenever appropriate, assist in the development of program products. This committee will be organized from representatives of county and State agencies, voluntary health organizations, universities, industry, and insurance companies. The State HERR program will assist local intervention projects and communities that are taking an organized approach with an annual prevalence survey. This assistance will include

training of survey personnel on the use of the CDC-recommended Common Data Items instrument, and the prescribed methodology for selecting a random sample. Telephone etiquette and procedures, timetables and schedules for surveying, batching, and processing data will also be included. The use of prevalence data in planning will also be discussed. The survey data will be compiled by the State HERR and distributed back to the communities for use. It will also be distributed to CDC, the HERR Advisory Committee, State agencies, and other interested and appropriate groups. As a member of the State's committee on Chronic Disease Strategy, the HERR State program will identify and improve chronic disease surveillance. Inquiries will be made on the accessibility of morbidity and mortality data already available within State agencies. HSA's, the veterans hospital, insurance carriers, medical schools, HMO's, and voluntary health organizations will also be contacted. An Advisory Committee will make recommendations on improving surveillance and data collection instruments. Local intervention projects will be asked or required to collect prevalence data on target groups and communities. Technical assistance will be provided to communities taking an organized approach to risk reduction. This will include consultation on the prevalence study, training for prevalence study, encouragement, site visits, assistance with utilizing prevalence data for planning, and support in the application for funding. The State will monitor the degree of community organization, the success in accomplishing the survey workplan, and the utilization of the prevalence data by the community. Efforts will also be made to stimulate new communities to undertake an organized approach to risk reduction.

81P-0494
Adolescent Smoking and Alcohol Project.
Putnam County District School Board, Bostwick, FL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Adolescent Smoking and Alcohol Project is designed to (1) increase the knowledge of target students (1,500 from 1 middle and 1 high school) about the risks of alcohol and tobacco use; (2) increase student knowledge of personal attitudes and values related to alcohol and tobacco use; (3) increase to 75 the number of students at each pilot school who can follow the steps of a prescribed decision-making model; (4) increase the opportunities for target group students to practice specific techniques for resisting direct social pressure to smoke and drink; (5) establish a task force of health teachers from the pilot schools, community health agencies, parents, project staff, and students to plan, monitor, and evaluate the program; (6) increase from 0 to 3 the number of health-related agencies actively involved in the program; (7) determine the prevalence of risk factors in Putnam County; (8) establish a minimum of 4 community goals and objectives aimed at reducing health risks associated with the use of alcohol and tobacco in Putnam County; (9) establish a stop-smoking program for students and teachers; (10) increase from 0 to 25 the number of pregnant students enrolled in an "Education for Pregnant Students Program"; (11) train 20 peer counselors; and (12) increase to 25 the number of students at pilot schools participating in Alateen-type programs. To accomplish these goals, the program will (1) conduct a 2-day work session for project staff, school health instructors, and community representatives to select appropriate instructional materials; (2) conduct pre- and posttests; (3) use values- and attitude-clarification activities; (4) conduct inservice training activities for personnel; (5) hold small group counseling sessions; (6) teach decision-making skills; (7) utilize community resources and appropriate health agencies; (8) conduct assertiveness training; (9) conduct stress reduction lessons; (10) prepare a school health education resource guide listing available speakers, materials, and other resources; (11) implement a stop-smoking program; (12) implement a program for pregnant teenagers; and (13) conduct peer counseling. The program's effects on students will be measured through commercially produced instruments or those developed by the program. An ongoing evaluation will be conducted for the duration of the project. Data will be collected from norm-referenced tests, questionnaires, surveys, observational records, parent input, teacher logs and reports, recorded minutes, rosters, and meeting schedules.

81P-0495
Alcohol and Tobacco Abuse Intervention Project.
Florida Citizens' Commission on Alcohol Abuse, Inc., Miami, FL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Tobacco and Alcohol Abuse Intervention Project is designed to (1) assess the current extent of alcohol and tobacco use and abuse by the target group (Hispanic youth in Dade County); (2) acquire and categorize alcohol, tobacco, and voluntarism information; (3) prepare 4 plans for training peer leaders and youth, the agency staff, the community, parents, and volunteers; (4) prepare supportive materials for training and education plans; (5) serve as a resource center for materials on alcohol and tobacco abuse and voluntarism; (6) increase the coordina-

tion efforts between the alcohol and tobacco intervention resources in Dade County; (7) secure the support of the Hispanic community; (8) designate a minimum of 50 community resource persons for training; (9) provide a minimum of 6 trained peer leaders to the community; (10) provide an educational program to a minimum of 4,000 Hispanic youth; (11) assure that a structured volunteer program is established; and (12) recruit a minimum of 10 volunteers to provide outreach intervention and support services. To accomplish these goals, the program will (1) develop liaisons with organizations in the Hispanic community; (2) establish a steering committee of 15 community members; (3) conduct a literature review; (4) copy, categorize, and file information obtained; (5) emphasize, in community education, the confusion and ambivalence of American society which make alcohol and tobacco emotionally charged subjects; (6) recruit peer leaders, whose training will follow the CASPAR (Cambridge and Somerville Program for Alcoholism Rehabilitation) curriculum but will be modified according to the specific needs of the Hispanic community and with the addition of a tobacco use and abuse section; (7) integrate peer leaders into the school system by holding structured rap sessions during free periods and by serving as co-instructors in health classes or driver education classes; (8) teach peer leaders to use puppetry shows to elementary schoolchildren about tobacco and alcohol; (9) train volunteers in outreach and support services (volunteers will canvass door to door with intervention materials and work in information booths at public gatherings and health fairs); (10) train teachers; and (11) use media. Evaluation will consist of pre- and posttests of participants; interviews with parents, teachers, and key community and school decision makers; and pre- and postassessment of peer leaders. Consultants experienced with the CASPAR model will be utilized in the development and processing of evaluation tools.

81P-0496
Apalachee Health Education for Adolescents.
Apalachee Community Mental Health Services, Inc., Tallahassee, FL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Apalachee Health Education for Adolescents is designed to (1) organize a community alcoholism and smoking prevention project; (2) provide educational information to at least 2,250 children in target schools; (3) provide at least 300 preschoolers with a 6-week alcohol education program; (4) establish ongoing youth councils; (5) provide 3 pilot teenage smoking conferences to 500 seventh graders from Leon, Gadsden, and Madison Counties; (6) provide 4 seminars to at least 60 minority pregnant teenagers in a teenage parent program; (7) provide 3 alcohol information seminars to at least 90 faculty members; (8) present at least 4 smoking cessation clinics for a total of 80 persons; and (9) extend all programs to surrounding counties (years 2-5). To accomplish these goals, the program will conduct (1) smoking and alcohol education classes, which will cover values clarification, information on the physical and emotional changes of adolescence, decision making, the variety and effect of peer relationships, information on the effects of tobacco and alcohol consumption, positive benefits of social use of alcohol and tobacco in a historical perspective, the nature of dependence upon chemicals, media and other advertising efforts and their effects on behavior, national trends, laws affecting alcohol and tobacco, and means to help drinkers and smokers; (2) day-long conferences for seventh graders to teach decision-making skills; (3) smoking cessation clinics; (4) preschool alcohol and smoking education classes directed at decision-making skills; (5) youth councils to assist project staff and school faculty in prevention efforts; (6) peer counseling; (7) a fetal alcohol and smoking education program; and (8) teacher training. For evaluation, the Centers for Disease Control's common data instrument will be administered. Evaluation will be accomplished through pre- and posttests for each of the training modules over a 5-year period; knowledge acquisition measurement; and a longitudinal study to measure overall project objectives. Evaluation will be conducted by the Department of Community Psychology, Florida A. & M. University.

81P-0497
Panhandle Region Health Hazard Appraisal and Lifestyle Promotion Project.
Florida Department of Health and Rehabilitative Services, Health Program Office, 1323 Winewood Boulevard, Tallahassee, FL 32301
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Panhandle Region Health Hazard Appraisal and Lifestyle Promotion Project is designed to increase knowledge about specific risk factors and unhealthful practices, aid in the reduction of those risks, and assist in the development of more healthful practices. Specific objectives include (1) the expansion of the health education-risk reduction (HERR) program to additional settings in Bay County, (2) the dissemination of information to professionals and health education organizations regarding the potential use of health hazard appraisal (HHA) tools, (3) the extension of the project director's role as a technical

advisor to areawide professionals who want to implement their own health education programs, (4) the enhancement of community awareness regarding potential benefits of the HERR program, (5) the continued development and dissemination throughout the Florida Panhandle of an HERR directory which identifies local agencies and organizations involved in the various aspects of health promotion, (6) the development of ongoing counseling and referral with the faculty and staff at Gulf Coast Community College, (7) the development of ongoing continuing-education programs with the faculty and staff of Gulf Coast Community College and their support systems, and (8) the dissemination of an evaluation report of the educational intervention programs to all participants in the Gulf Coast Community College HERR program. To accomplish these tasks, (1) available HHA tools will be reviewed and selected for use, (2) college facilities will be employed for technical and laboratory aspects, and (3) appraisal results will be used to establish ongoing risk reduction support groups with a community health educator as coordinator. The project will seek to increase awareness of HHA tools and their potential uses through personal contact, technical assistance, and through at least one regional workshop. A newsletter will notify health care personnel regarding all available activities and resources relevant to HHA's and risk reduction. A comprehensive listing of available programs will also be drawn up. The target group consists of a self-selected group of employees from Gulf Coast Community College and professionals from over 200 health-related agencies which provide programs for pregnant women and teenagers. Evaluation will be conducted on the basis of participation and dropout rate and relative change in risk levels between participants and nonparticipants in the risk reduction support groups, with a 1-year posttest. Followup questionnaire responses will be solicited from the target population to measure awareness level after 1 year regarding HHA and the initiation and placement of new programs. Questionnaires will also be used to seek detailed information on implementation of specified health hazard measurement for respondents' programs and implementation of risk reduction programs.

81P-0498
Partners in Learning Healthy Lifestyles.
North Florida Mental Health Center, Inc., FL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Partners in Learning Health Lifestyles is designed to (1) initiate a positive change in behavior, attitudes, and knowledge in regard to drinking and smoking among target students (1,746 students in grades 5-8 in 4 Suwannee schools); (2) increase appropriate role modeling behavior in regard to the use of alcohol and tobacco, encourage an appropriate attitude toward these substances, and increase knowledge about the effects of drinking and smoking among 100 percent of the students' parents; (3) increase knowledge about smoking and alcohol abuse among school personnel; (4) increase knowledge of the principle of affective education among school personnel; (5) increase awareness of the project among community agencies; and (6) convince community and minority agencies of the project's worth and effectiveness. The project will be conducted through (1) student support centers at each of four target schools to provide direct services to youth, teachers, and parents, as well as consultation and supervision to school personnel; (2) lifestyles curricula, including a didactic course that focuses on the health consequences of smoking and drinking and an affective education course that focuses on values clarification, self-assessment, and decision-making skills; (3) a teacher training course consisting of six consecutive sessions; (4) a parent involvement course consisting of five education sessions to increase parents' ability to understand the health consequences of smoking and alcohol use; (5) a school component to be conducted in 9-week cycles; and (6) a community component consisting of a summer day camp series, a run for health, and an outreach program. Evaluation will consist of (1) program evaluation, including an analysis of level of participation, numbers served, completion of some program aspects, and social and demographic characteristics of those served; (2) participant evaluation, consisting of pre- and posttests of participants regarding knowledge and attitudes on smoking and alcohol; and (3) community evaluation, consisting of measurement of community awareness of the program, community acceptance, and specific changes in key indicators of alcohol and tobacco use by youth.

81P-0499
Smoking and Alcohol Use Prevention in Children and Adolescents of Nine Rural School Districts.
School Board of Washington County, Panhandle Area Educational Cooperative, FL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Use Prevention program is designed to (1) prevent alcohol consumption and smoking in students in the target group (1,250 fifth grade students and their parents in 10 schools in 9 school districts in the first year, and sixth and seventh grade students and their parents in the second and third years); (2) stop experimentation with alcohol and cigarettes, and encourage those

who have already begun to use them to quit; and (3) increase awareness of responsibilities of the adults involved in supervising these students. To accomplish these goals, the program will (1) conduct needs assessment, using the common data instrument and a random telephone survey (minimum of 500); (2) develop a curriculum with equal emphasis on smoking and alcohol use; review and adopt available program materials, including the School Health Curriculum Project; encourage active student participation in the study; motivate students to increase their knowledge; and reinforce earlier presentations; (3) develop a teacher training program; (4) train teachers; (5) implement the program in 10 selected schools identified as high risk; (6) conduct a presentation for parent groups and civic groups; (7) monitor the classroom curriculum and provide technical assistance to teachers; (8) collect and maintain data; (9) revise the program as necessary; and (10) evaluate results. Evaluation will be continuous through project management documentation records; pre- and posttests will be administered. Evaluation design will be constructed either through the State project or by an outside evaluation specialist.

GEORGIA

81P-0500
Health Education-Risk Reduction (HERR) Grant Project, Georgia.
Miner, K. R.
Georgia Department of Human Resources, Division of Physical Health, 47 Trinity Avenue, S.W., Atlanta, GA 30334
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Georgia was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. Local intervention grantees will inventory health resources within their geographical area. Sample urban and rural communities will be inventoried. Voluntary inventory in other communities will be encouraged. Currently available inventories will be updated. State HERR staff will compile inventories and disseminate information to interested agencies statewide via a quarterly newsletter. Communication with HERR programs will be facilitated by personal meetings, phone calls, newsletters, meetings, memos, or news releases. Documentation will be made in order to evaluate the effectiveness of the network. A select panel, chosen from State, local, and community agencies, will meet on a quarterly basis to coordinate inventory, liaison, data collection, community assistance, and evaluation. The CDC Common Data Items survey instrument will be used to collect prevalence data in two State-selected communities (one urban and one rural). The HERR staff will coordinate the collection of prevalence data from communities receiving intervention grants. The HERR staff will develop and provide guidelines outlining survey procedures. They will also provide onsite visitation as requested, referral to other identified guidance sources, and assistance in locating volunteers to do survey work. The HERR staff will also develop the methodology for locating previously collected prevalence data. HERR staff will identify data sources from risk-related inventories utilizing previously collected data and current investigations. Previously collected data will be coded and correlated with Common Data Items analyzed and evaluated; established data bases will be updated. Data will be tabulated into a useful instrument and distributed to reporting agencies along with recommendations. A liaison with State agencies, departments, and other health-related programs or organizations will be established with the major intent of improving surveillance. HERR staff will coordinate communications with communities and organizations interested and involved with risk reduction. These communications will focus on defining an organized approach to risk reduction, grant priorities, methodology, workplans, school curricula development, and resource identification.

81P-0501
Health Education-Risk Reduction Project.
Health Action Associates, Inc., Atlanta, GA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Project is designed to (1) develop, implement, and evaluate a school-based health education program to deter members of the target group (19,254 Hall and Habersham County students in grades 1-12) from the use of tobacco and alcohol; (2) reduce the number of regular users of tobacco or alcohol by 20 percent; and (3) reduce the rate of increase of new users of tobacco or alcohol by 40 percent. The project will

consist of assessment, implementation, and evaluation. An education phase to be implemented in all grades will be designed to be age appropriate and equip students with information needed to make informed choices; a puppet show will be utilized to impart knowledge of the aspects and consequences of substance abuse; and the Life Coping Skills Program of the Odyssey Counseling Center will be modified for middle school youth. A survey of all students will be devised to determine the prevalence of tobacco and alcohol use and changes in attitudes about such use. The results will be written in a publishable report format.

81P-0502
Model Program for Alcohol and Smoking Education.
Wayne County Commission on Alcohol and Drug Abuse, Inc., and Pineland Mental Health and Mental Retardation Center, Statesboro, GA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Model Program for Alcohol and Smoking Education is designed to (1) educate teachers, at-risk school students, and the community about lifestyle behaviors that contribute to ill health; (2) show, through evaluation of risk reduction education programs, that lifestyle changes can be effected; and (3) monitor program effectiveness in terms of decreases in alcohol consumption and smoking. The program will utilize a pretested alcohol education curriculum entitled RAMP (Replication of Alcohol Model for Prevention). RAMP emphasizes teacher training through workshops for student education in alcohol and smoking, peer training, and evaluation. The superintendent of schools will require all health and physical education teachers to be trained in the program, and at least three workshops per year lasting 40 hours each will be presented. The target group will consist of 500 students in grades 5-9 and their 30 teachers. Workshops and student implementations will be pre- and posttested. Also, a public awareness effort will be maintained. A base-line survey will allow for assessment of the likelihood that students may develop some chronic diseases. Repetition of the survey at the end of the second or fifth year may be initiated. Participants will be administered a smoking and alcohol education attitude inventory with a posttest upon workshop completion.

GUAM

81P-0503
Health Education-Risk Reduction (HERR) Grant Project, Guam.
Cruz, K. A.
Guam Department of Public Health and Social Services, Health Education and Nutrition Section, P.O. Box 2813, Agana, GU 96910
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Efforts of the Health Education-Risk Reduction (HERR) Grant Project in Guam are directed towards planning for (1) an inventory of programs and services in HERR, (2) working relationships with other organizations, (3) determining prevalence of risk factors for chronic disease, (4) surveillance for chronic disease morbidity and mortality data, and (5) effecting organized approaches to risk reduction.

HAWAII

81P-0504
Health Education-Risk Reduction (HERR) Grant Project, Hawaii.
Lipsher, J. D.
Hawaii State Department of Health, Health Education-Risk Reduction Project, 548 Kapahulu Avenue, Honolulu, HI 96815
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Hawaii was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. During FY 1981 a plan will be formulated to categorize activities as health promotion, health education, wellness, or risk reduction programs or services. A retrospective study will be made of health promotion activities that have been ongoing or initiated

since 1978. Working relationships with these organizations will be established. An evaluation will also be made to determine how the existing inventories are used. This will look at the purpose of use, for whom these collections of information were made, and how they were utilized. A community meeting, of members of the organizations who had previously compiled inventories, will be called to discuss their results and levels of success in reaching their goals and objectives. They will also be asked to develop an acceptable definition of risk reduction programs and formulate guidelines on the methodology of obtaining a new inventory. The suggested definition of risk reduction programs will be reviewed and discussed by the HERR State staff and presented to the Project Advisory Council for discussion, revision, and final approval. Workshops and training sessions for key contact persons in direct community services will be held to assist people in the use of the inventory and to obtain their evaluation of the entries and updating schedule. The inventory system will be reviewed annually. The functions of the HERR program will be communicated to other units of State government. Opportunities will be made for State agencies to participate by sitting on committees, by identifying mutual program goals, and by developing plans for mutual support. Source input from interested agencies and individuals will be documented by the establishment of contact with relevant programs, the documentation of common program goals, objectives and activities, and by participation in each other's programs that are of common interest, and in assistance requested or provided in planning and implementation of common program goals. A listing of risk reduction programs in State government will be made. Working relationships with these programs will be evidenced by serving on project committee functions, involvement in program planning, exchanging data and program information and co-involvement in activities. Working relationships with voluntary, public, and private agencies will be documented by their involvement with HERR program activities, and HERR's assistance to capable groups, as evidenced by explanation of program guidelines, participation in common activities, providing direction and guidance in identifying risk factors, gathering morbidity and mortality data, providing guidance and direction in the incorporation of CDC-recommended Common Data Items, and periodic meetings. Methods to determine the prevalence of risk factors will be established by the identification of existing sources of data gathering and expertise among units of State government, identification of community agencies with data-gathering expertise, and development of a methodology to determine risk factor prevalence. Technical assistance will be provided to groups identified as having an interest in determining prevalence of risk factors in their community. Risk factor data will be assembled, synthesized, and distributed among interested and involved groups, organizations, and individuals through a series of workshops. An inventory of all known existing sources of data relating to chronic disease morbidity and mortality will be made by developing access to existing data sources in State agencies, voluntary agencies and organizations, and private organizations. Data review expertise at the State HERR will be developed at the pretest level. A data review subcommittee task force of the Project Advisory Council will be formed. Data will be reviewed to determine suitability for risk reduction programs or surveillance activities. Behavioral components will be categorized, and the specific population segments at risk will be determined. Chronic disease surveillance will be improved through developing working relationships with existing sources of data collection, grouping of entries from the inventory that address special chronic disease, and developing a mechanism to collect and monitor risk factor prevalence. A data collection and retrieval system will be implemented to monitor risk factor prevalence among at least 15 intervention projects listed in the inventory. The State HERR program will link the intervention grantees to the Federal system administratively by providing program guidelines, Federal requirements, contracts, and transmittal of grants and other requests. The State will monitor progress, provide technical assistance in setting up data collection systems, share data information and resources, assist in carrying out Federal requirements and provide access to national data. Technical assistance will be provided to develop expertise among grantees in data collection, data analysis and interpretation, evaluation, and program planning and development. It will also provide assistance in determining prevalence data and provide continuing educational opportunities. Similar services will be provided to nonfunded HERR projects as well as the access into the organized risk reduction structure. The State will also provide media publicity, public relations, linkages to community networks, and data and feedback linkages with consumers. For the consumers, the State will provide greater awareness of risk reduction programs, increased access through greater awareness, information on the benefits of an organized approach, increased knowledge of behavioral risk factors, and increased motivation to limit or eliminate risk factors that have behavioral origins.

81P-0505
Employee Lifestyle Program.
Kaiser Foundation Health Plan, Inc., 1697 Ala Moana Boulevard, Honolulu, HI 96815
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Employee Lifestyle Program will develop model worksite health education programs that can be evaluated in terms of how they motivate individuals to make choices and changes needed for a healthier life. The concept will eventually be introduced to other companies. Specifically, employees will be appraised and counseled. They will participate in interviews, focus groups, and other activities necessary to determine the educational strategies that work best. Communications issued by the program will emphasize the switch to new behavior patterns rather than the change from old behavior patterns. Onsite risk reduction programs will focus on self-management, stress reduction, aerobic exercise, and nutrition; outside resources will also be utilized. A file maintenance system will input, validate, and update the records of employees participating in the program. Between 200 and 300 employees of Kaiser-Permanente will participate. The following data will be collected: (l) information on age, sex, race, and health and safety habits, medical history; (2) certain types of clinical data, such as blood pressure, height, weight, and urinalysis; (3) physician's decision on whether or not an employee can participate in an exercise program; (4) historical data; (5) utilization of health services; and (6) hours of sick leave used. Ongoing evaluation will measure changes in these base-line data elements through surveys, observations, tests, and questionnaires as well as participation in program activities. Intermediate variables, such as acceptance of risk and receptivity to various health promotion methods, will also be assessed. An outside consultant will evaluate the program's achievement of its first-year objectives.

81P-0506
Hawaii State Health Education-Risk Reduction Optional Program.
Hawaii State Department of Health, Health Education Office, l250 Punchbowl Street, Honolulu, HI 968l3
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Hawaii State Health Education-Risk Reduction (HERR) Optional Program is intended to (1) help health department employees understand and reduce their own risk of preventable disease and disability and thereby serve as exemplars to others in the community, and (2) train selected health department personnel to conduct health appraisal and risk reduction programs for departmental clientele, employees of other State agencies, and the general public. These goals may be attained through the following long-term and short-term objectives: (1) reduce risk-creating behavior in health department personnel by at least 35 percent; (2) conduct at least one risk reduction program for clients or the general population on Maui, Hawaii, and Kauai, and in each health center on Oahu; (3) enlist the participation of every department of health educator and at least l0 percent of other health department workers in prevention programs in the planning or conducting of risk reduction programs; (4) increase the awareness of at least 50 percent of employees of their personal health risk behavior through health hazard appraisal testing at Kinau Hale in year 1 and at Lanakila Health Center and Diamond Head Health Centers in year 2; (5) have at least 50 percent of employees who participated in health appraisal testing contract to make positive behavioral changes; (6) have at least 50 percent of employees who participated in health appraisal testing attend one risk reduction workshop; (7) have at least 20 percent of health department employees who participated in risk reduction programs modify their behavior to reduce at least one risk factor; and (8) have the health educator assigned to the Wellness Program participate in planning and carrying out the first risk reduction program and learn the necessary skills and techniques to organize and coordinate additional programs. The specific methodology for implementing the program activities at each center includes: (l) recruit and train selected health department personnel in health appraisal testing, risk-profile interpretation, and individual self-contract assistance; (2) survey employees at the remaining two worksites about knowledge of and attitudes toward health risks to obtain baseline data; (3) conduct health appraisal for employees utilizing a computerized health risk appraisal questionnaire along with height and weight, blood pressure, and cholesterol measurements; (4) consult with employees after results of health risk appraisal are obtained, interpret individual risk profiles, and initiate individual self-contracts for risk reduction program participation; (5) develop appropriate followup risk reduction workshops in areas of stress, nutrition and diet, physical fitness and exercise, and smoking, and provide basic health information plus alternative approaches to changing unhealthy behavior patterns through behavior modification techniques; (6) survey employees again to determine changes in knowledge and attitudes about health risks; and (7) conduct a second health appraisal 1 year after programs-workshops have been completed to determine changes in actual health risk practices. The target group consists of Hawaii State Health Department employees, who number approximately 5,000. During the first year, department employees from the Kinau Hale facility were offered the opportunity to participate. The employees at Lanakila and Diamond Head Health Centers will be offered the opportunity to participate in year 2. During the following 2 years, the program will be expanded to include employees at the remaining department facilities at Oahu and the neighbor islands. By determining whether short-term objectives are being met, process evaluation can be con-

tinually monitored. Outcome evaluation will be determined by pre- and postsurveys and appraisals. Employees at the three sites will be surveyed to determine health risk knowledge and attitudes before and after risk reduction workshops. Those employees who participate in the health risk appraisal program will complete a second health risk appraisal 1 year after completion of workshops to measure changes in behavior and practices.

81P-0507
Health Intervention Program (HIP).
Leilehua High School, Wahiawa, HI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Intervention Program (HIP) is designed to (1) reduce by 20 percent the use of alcohol, tobacco, and marijuana in the target population (5,800 students in grades 7-12 at 5 schools in the Central District of Oahu) over a 5-year period; (2) establish a health intervention program at Leilehua High School for students of the 5 target schools; (3) establish a referral and assistance center with community liaisons in 3 areas (smoking cessation, alcohol abuse intervention, and pregnancy support services); and (4) establish a health education resource center with audiovisual and other resource materials for use by the referral and assistance center, other schools, and community organizations. The program will be conducted through (1) direct individual and group services through the referral and assistance center; (2) the health education resource center for dissemination of audiovisual and other materials, presentations by resource speakers, and development of educational programs; (3) peer counseling; (4) training of teachers, parents, and health aides; (5) use of outside resources for the smoking cessation program; (6) development of an alcohol abuse program; and (7) provision of pregnancy services for 30-40 at-risk females per year to prevent fetal damage. For evaluation, a questionnaire will be refined to assess student, faculty, staff, and parental knowledge, attitudes, and practices related to smoking and alcohol use. Descriptive material of population studies will be summarized. Analysis and reporting of data will take until the end of the first academic year. The whole survey pattern will be repeated in the project's final year. Each component of the referral and assistance center and the health education resource center will have its own evaluation form to assess consumer satisfaction and behavioral changes observed during or immediately after completion of a particular learning activity or service.

81P-0508
March of Dimes Education Project (MODEP) to Deter Smoking and Alcohol Use in Children.
Chapter of the Pacific March of Dimes Birth Defects Foundation, Honolulu, HI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The March of Dimes Education Project (MODEP) is designed to (1) present an educational and support program to deter smoking and alcohol use by the target population (1,077 students in grades 5-8 in Kona public schools); (2) expand awareness of and responsibility for such a program to individuals and agencies within the community who do or can influence the target group; (3) utilize the media to stimulate and reinforce responsible behavior regarding tobacco, marijuana, and alcohol use; and (4) develop evaluation tools to assess the impact of the program. To accomplish these goals, the program will (1) review available literature, films, and materials, and develop a program format; (2) pretest students and survey their families; (3) deliver five 40-minute classroom sessions to combined fifth and sixth, and seventh and eighth grade classes and reinforce the material with informal conversation at lunchtime or on the playground; (4) give presentations at one PTA meeting in each school and at community organizations and provide inservice seminars for school counselors and teachers and health professionals; and (5) broadcast health messages and talk shows on radio station KKON and publish health messages in West Hawaii Today. For evaluation, a pre- and posttest will be administered to measure increases in knowledge, healthy attitudes, self-esteem, and self-management regarding smoking and alcohol, and again to determine retention of knowledge and positive attitudes. A survey will provide data on the use of alcohol, tobacco, and marijuana in the target population and their families. Survey items will be based on the Centers for Disease Control's common data items. The real measure of change might be determined by repeating these evaluations in 3-5 years. Evaluative "opinionaires" administered to teachers, parents, and community participants will provide subjective data.

IDAHO

81P-0509
Health Education-Risk Reduction (HERR) Grant Project, Idaho.
Patterson, J.
Idaho State Department of Health, Bureau of Consumer and Health Education, Statehouse, Boise, ID 83720
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Idaho was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The directory of existing HERR efforts within the State will be finalized and distributed to cooperating State agencies, voluntary organizations, and individuals. The directory will be updated annually by phone calls and personal visits. Staff will make personal contacts with each agency listed in the directory. Contact information sheets will be developed to reflect future plans, directions, and commitments of the organization. A survey instrument using CDC Common Data Items will be developed, pretested, and revised. The survey instrument will be implemented in two school districts and one community in each health district within the State. A statewide inventory of existing surveillance activities and chronic disease data sources will be established. A plan will be developed to improve statewide surveillance systems. Risk reduction assistance to communities is in the planning stage.

81P-0510
Coping With Stress.
Healthwise, Inc., Boise, ID
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Coping With Stress is designed to (1) reduce the prevalence of cigarette smoking among 12- to 18-year-olds by 10 percent; (2) reduce the prevalence of alcohol abuse among regular 12- to 18-year-old users by 10 percent; (3) increase by 10 percent the number who regularly use relaxation techniques to reduce stress; (4) foster the development of autonomy, improve self-esteem and confidence, and make adolescents feel more in control of their lives; (5) encourage recognition that relaxation techniques and anxiety management skills are viable coping strategies, and that alcohol and tobacco abuse are ineffective coping techniques; and (6) enable adolescents to do progressive muscle relaxation, assert themselves in resisting peer pressure, and analyze the pros and cons of significant decisions. To accomplish these goals, the program will (1) offer four workshops for teachers, counselors, and students on the school newspaper staff; (2) offer six workshops on a monthly basis to students, conducted by health staff, with support from teachers, counselors, and students interested in team teaching; (3) monitor behavior related to program objectives; (4) give questionnaires and interviews to assess changes in stress, smoking, and alcohol use patterns; (5) survey current cigarette and alcohol use by printing an article and questionnaire in the school newspaper; and (6) have participants complete a detailed pre- and postprogram behavioral inventory. The target group will consist of 150 students in Boise High School and 10 of their teachers, counselors, and administrators; and 100 students at North Junior High and 10 of their teachers, counselors, and administrators. The populations of both schools include Mexican Americans, native Americans, and blacks. Preliminary data on patterns of use of alcohol, cigarettes, and stress reduction techniques will be gathered for both the senior and junior high school populations. Change in behavior will be measured through a postprogram test.

81P-0511
Growing Younger.
Boise City Senior Citizens Center, and Healthwise, Inc., Boise, ID
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Growing Younger is designed, in 5 years, to (1) improve the health of the target population (2,500 Boise citizens over 60 years old) by reducing major health risks related to heart disease, cancer, obesity, diabetes, depression, and hypertension; (2) increase the group's frequency of exercise by 10 percent; (3) reduce age-specific resting heart rates by 5 percent; (4) increase age-specific frequency of social contacts by 10 percent; (5) increase the frequency of nonspecific relaxation practices by 10 percent; (6) reduce the number of persons who smoke by 10 percent; (7) reduce the average diastolic blood pressure by 5 percent; (8) reduce the average number of pounds overweight by 10 percent; and (9) reduce the average percentage of body fat by 10 percent. To accomplish these goals, the program will (1) train 2,500 elderly persons from the

total elderly population of about 24,000; (2) invite the elderly to participate by contacting approximately 8,000 by mail or telephone and by holding neighborhood parties; (3) administer a health risk appraisal to those interested, and collect a $15 registration fee from those who can afford it (a $5 rebate will be given to all elderly persons who attend all 4 sessions); (4) hold 16 parties and 4 general information sessions each month; (5) recruit participants through churches and community and elderly groups; (6) conduct four 90-minute sessions, including introduction and screening, self-care and fitness, self-care and nutrition, and appraisal results and a growing younger plan; (7) introduce a voucher-referral system to cover as much as 50 percent of the regular program price; and (8) conduct booster sessions 6 months after completion of the basic 4-session series. Evaluation will include (1) assessment of risk factor and behavioral changes among program participants, (2) assessment of process objectives, (3) assessment of risk factor and behavioral changes among the elderly in the general population, and (4) assessment of the program's impact on health care costs. Changes in weight, percentage of body fat (skin-fold method), blood pressure, and resting pulse will be measured. Changes in exercise frequency and intensity, social contacts, smoking habits, and purpose in life-stress measures will be determined by questionnaire. Changes in knowledge, attitudes, and values will be determined by pre- and postquestionnaires. Annual surveys will show the degree to which program objectives are reached.

81P-0512
Injury Surveillance-Accident Safety Demonstration Project.
Department of Health and Welfare, Bureau of Consumer and Health Education, Statehouse, Boise, ID 83720
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Injury Surveillance-Accident Safety Demonstration Project is designed to (1) ensure that all parents of preschool children in the county possess a home safety education package; (2) increase the public's knowledge of prevention of the four leading causes of injuries among children (poison, automobile accidents, falls, and burns); (3) increase parents' awareness of the importance of ipecac syrup; (4) develop a statewide children's injury surveillance data system; (5) initiate and coordinate a community campaign for the prevention of childhood accidents in Twin Falls, Idaho; and (6) establish working relationships with the U. S. Consumer Product Safety Commission, Department of Transportation, and Public Health Service to produce a home safety education package. To accomplish these objectives, (l) local hospital childbirth classes will offer the home safety education package; (2) a comprehensive media campaign of 30-second television spots, radio spots, and news releases will be implemented; (3) Project Ipecac, initiated by the Idaho State Pharmacy Association, will be utilized; (4) the State Injury Surveillance System will be improved to provide necessary data for communities that wish to offer education on childhood injury intervention techniques, while the three poison control centers and six regional emergency hospitals will provide useful childhood-injury-related data; and (5) emergency room injury admissions will be studied by phone surveillance, and injury morbidity data will be collected from local physicians. The preschool population of Twin Falls County, Idaho, is the target group. Evaluation will include pre- and postquestionnaires to determine parents' attitudes toward childhood accidents and safety measures. Three additional hospitals in southeast Idaho may be incorporated into the program to complete the Children's Injury Surveillance System.

81P-0513
Risk Reduction Grant--Injury Prevention Demonstration Project.
Department of Health and Welfare, Bureau of Consumer and Health Education, Boise, ID
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Risk Reduction Grant--Injury Prevention Demonstration Project is designed to (1) measure whether injury prevention intervention is effective in lowering injury morbidity among preschool children, and (2) lessen injury morbidity among preschool children in the long run. To accomplish these goals, parents will be separated into control and experimental groups. Parents in the experimental group will meet in small groups (eight or less) in participants' homes for two educational sessions in injury prevention methods. The second session will take place 2-3 weeks after the first. Parents will be asked to apply injury prevention methods in their homes and cars in the interim. Data will be gathered through home visits, phone calls, and emergency room records, and comparative techniques will be used on data gathered from control and experimental groups. The target group will consist of 600 parents of preschoolers in Twin Falls County in the first year, and parents of at least 1,200 preschoolers by the 18th month. Quarterly data summaries will be prepared beginning in the sixth month of the project, and preliminary analysis of the data will be conducted at the end of the 12th month. At the beginning of the second year the data will be fully analyzed, and an analytic report will be prepared by the middle of the third year.

ILLINOIS

81P-0514
Health Education-Risk Reduction (HERR) Grant Project, Illinois.
Knobloch, R. S.
Illinois Department of Public Health, Division of Education and Information, 525 West Jefferson, Springfield, IL 62761
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Illinois was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The inventory will be conducted in two phases. Phase I involves data gathering and coding of health education services and will be conducted by the University of Illinois. In Phase II, this information will be verified, corrected, and a final version of the computer tape delivered to the Illinois Department of Public Health. The State has established and will continue working relationships with the following organizations: (1) University of Illinois--contract to conduct an inventory and cooperative efforts to assist community agencies to develop intervention projects; (2) Statewide HeaLth Coordinating Council--the State is negotiating with the SHCC to use $30,000 to assist communities to develop and plan risk reduction programs. Communities which applied for but did not receive Federal support, and are willing to undertake organized approaches to risk reduction would then still be able to conduct prevalence surveys, inventory community services, and set objectives for the purpose of generating local resources. The applicant is also negotiating with the SHCC to carry out a radio and television awareness campaign for each of the six risk factors; (3) The Illinois State Board Of Education--the applicant and the Board of Education have agreed that there is a need to train and upgrade health education teachers; (4) The Division of Alcohol Prevention--data collected by this Division has been made available to be used by local communities and organizations in the development of intervention projects; (5) Interagency Council on Smoking--the State participated in the Council's annual antismoking program in Chicago and assisted the establishment of a council in Rock Island; and (6) Governor's Council on Fitness and Health--the applicant and the Council have discussed fitness programs in the workplace. The State will use instruments and techniques recommended by the Centers for Disease Control for gathering prevalence data in Illinois. The State plans to obtain hospital discharge data from the Illinois Cooperative Health Data System as one part of this system. The State has provided consultation to a number of agencies to develop intervention proposals. By September 30, 1981, at least four agencies not funded through the HERR project will demonstrate continued interest in the program by undertaking the following activities: (a) four agencies will coordinate and participate in conducting prevalence surveys and inventories of community services; (b) two of the agencies will coordinate and undertake risk reduction intervention programs using resources available in the community; (c) two of the agencies will apply for funds from sources identified by the risk reduction project. By December 31, 1980, the staff of the funded agencies will demonstrate the importance and feasibility of collecting prevalence data by attending an inservice training program dealing with methods of conducting prevalence surveys. By June 1, 1981, each funded agency will have planned and conducted a risk factor prevalence survey which meets the CDC-recommended criteria. By September 31, 1981, prevalence data from funded communities will be available to the CDC, the Illinois HERR Project, and the communities from which data were collected.

81P-0515
Health Education-Risk Reduction Intervention Program.
Illinois State University, Normal, IL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Intervention Program has several components. For schools in the risk reduction program, objectives are to (1) increase curricular emphasis on risk areas in 90 percent of schools; (2) increase food selection options in 80 percent of schools; (3) increase awareness in 80 percent of classroom teachers of the need to support individuals attempting to reduce risks; (4) increase awareness of risk reduction activities in schools in 60 percent of families; and (5) increase knowledge of local health agencies and their activities in 60 percent of families. For participants in smoking cessation intervention, objectives are to (1) reduce blood pressure and pulse rate in 60 percent of participants within 1 month of smoking cessation; (2) decrease the number of respiratory illnesses in 50 percent of participants within the 6-month period following completion of the cessation pro-

gram; (3) increase scores on pulmonary function tests for 50 percent of participants who cease smoking; and (4) reduce stress through large muscle relaxation in 50 percent of the participants as demonstrated through a biofeedback mechanism. For participants in weight control intervention, objectives are to (1) reduce body mass by 20 pounds or the total number of pounds overweight, whichever is less, for 60 percent of participants; (2) reduce unplanned snacks for 50 percent of participants; and (3) increase amount of eating time to 10 percent longer for 65 percent of participants. To accomplish these goals, the program will (1) confirm the prevalence of risk factors within the target group by measuring height and weight; taking blood pressure; surveying prevalence of alcohol abuse, smoking, stress, and lack of physical fitness; and collecting data on risk factors and process along with all Centers for Disease Control common data items; (2) establish weight reduction interventions; (3) establish smoking cessation interventions; (4) sensitize parents, through a bimonthly newsletter, to the need to be supportive of children's efforts to reduce risk or maintain their status; (5) implement parent-teacher association support activities; (6) conduct inservice education for teachers; (7) conduct workshops for teams from each school district on risk reduction information and supportive behavior; (8) and hold inservice training for health education teachers. The target group will consist of 6,979 students in grades K-12, 491 teachers, 22 administrators, and 77 food service employees. Evaluation will be conducted through (1) random digit dialing in target communities to ascertain whether parents are aware of the program; (2) pre- and postsurveys of students, teachers, administrators, and parents on knowledge and attitudes; (3) pre- and postevaluation of students; and (4) evaluation by teachers, students, parents, and administrators as to their perception of success.

81P-0516
Transfer of Technology: A Rural Replication of the School Health Project.
Regional Superintendent of Schools, Red Bud, IL
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Rural Replication of the School Health Project is designed to (1) provide the target population (300 students in grades 5-7 from 3 attendance centers in Massac County) with health knowledge through a process that will develop health-promoting attitudes and behavior, and (2) provide a technical assistance base for the rural replication of the School Health Curriculum Project (SHCP). To accomplish these goals, (1) students will be involved with projects for an 8- to 12-week period; (2) each new project will be visited by a training staff member to discuss implementation issues; (3) activities involving school, family, and community members will be written into the curricula; (4) field trips will be planned to enhance effective linkages among the school, family, and community; and (5) appropriate evaluation techniques will be administered. For evaluation, pre- and posttests will be administered to participants in inservice training workshops. Cognitive growth will be measured by an SHCP assessment instrument, which is a part of the curriculum and will serve as a criterion of student performance in various areas. A questionnaire designed to measure aspects of the curriculum and student impact will be distributed to participants. The Centers for Disease Control's common data items will be used to establish base-line prevalence of risk factors.

INDIANA

81P-0517
Health Education-Risk Reduction (HERR) Grant Project, Indiana.
McClain, R.
Indiana State Board of Health, 1330 West Michigan Street, Indianapolis, IN 46206
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Indiana was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By September 30, 1981, information regarding current HERR programs within the targeted counties of Vigo, Monroe, Elkhart, Newton, Marion, and the city of Gary will be centrally located. By July 31, 1981, data collected from inventories within targeted counties will be easily retrievable and prepared for feedback upon request. By August 15, 1981, information will be disseminated to publicize the availability of the inventory instrument and the data currently gathered from the targeted counties. By August 31, 1981, seven counties beyond those targeted for coordinating HERR programs will be inventoried, data processed, and filed for HERR

programs and services. By September 1981 the State HERR program will establish and maintain working relationships with at least nine other agencies and organizations interested in HERR activities. By December 1, 1981, the State HERR program will have convened the following agencies and organizations to form the Indiana Health HERR Coordinating Council composed of: State Department of Public Instruction (Division of Pupil Personnel and Curriculum), State Department of Mental Health (Division of Addiction Services), Indiana Lung Association, Indiana Heart Association, American Cancer Society, Indiana Congress of Parents and Teachers, Indiana Association of Health Educators, Interagency Council on Smoking, State Health Planning and Development Agency. By May 1, 1981, the State HERR Coordinating Council will have produced plans for at least two new capacity building activities to assist local communities to reduce the prevalence of risk factors. By April 30, 1981, base-line data on the prevalence of risk factors will be collected and processed for targeted counties. State HERR consultant will provide consultation services during the planning sessions with community groups utilizing the "Model Standard for Community Preventive Health Services" and the "1990 Objectives for the Nation." By March 31, 1981, data relating to chronic disease morbidity and the prevalence of risk factors will be identified from information from the Indiana Hospital Association Hospital Discharge Study. By September 30, 1981, data relating to chronic disease morbidity and the prevalence of risk factors will be identified from information from the Household Interview, conducted by the Census Bureau, for the National Center for Health Statistics. Also by September 30, 1981, the following existing sources of chronic disease risk factor data will be reviewed to determine if items are available which are pertinent to risk reduction programs: (l) Hanes Project and Mobile Unit Survey, which are Household Interview Supplements; (2) Indiana State Board of Health--Health Planning and Development, Chronic and Communicable Disease Control, Public Health Statistics, Vital Records, Data Processing; and (3) State Agencies, i.e., Police, Motor Vehicles, Labor, and Fire Marshall. State agencies, departments, programs, or organizations will interact to improve the surveillance of chronic diseases and the associated risk factors. By February 1, 1981, the State HERR staff will develop a handbook for communities undertaking an organized approach to risk reduction. By June 1, 1981, the State HERR staff will have assisted at least five communities to undertake an OARR and to do program planning. By March 1, 1981, the State HERR program will have stimulated at least five communities in addition to those in the current program to undertake an OARR. The State HERR program will provide technical assistance and consultation to communities undertaking an OARR and provide information to communities about resources which they can use from the State-level and from the local level in and around their communities. A State HERR consultant will meet with a community group a maximum of three times to provide guidance in program planning and proposal preparation. The State HERR program will conduct a 3-day training workshop on program planning by February 1981 to promote common planning concepts and language and uniformity in format. A 2-day meeting will be conducted to promote the transfer of technology among communities and stimulate good performance. The progress, impact, and outcome of the intervention projects will be monitored by the State HERR program; 90 days after the end of the fiscal year, communities undertaking an OARR will be required to have completed their annual reassessment of the prevalence of risk factors.

81P-0518

Adolescent Smoking and Alcohol Use, Vigo County Organized Approach to Risk Reduction.

Katherine Hamilton Mental Health Center, Inc., Community Services Division, IN

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Adolescent Smoking and Alcohol Use program is designed to (1) combine the expertise of numerous community agencies involved in school health education; (2) promote health education as a major component in a health education consortium; (3) establish a peer leadership program that offers class sessions on wellness, including stress management and relaxation training as it applies to personal decision making about smoking, alcohol, and drug use; (4) reduce the incidence of smoking and alcohol use among junior high school students; and (5) provide peer counselor training for junior high and high school students that pertains to personal value systems, listening skills, communication patterns, helping techniques, and appropriate referrals. To accomplish these goals, the program will (1) conduct an initial and a reassessment survey of risk factors in the community; (2) concentrate risk intervention efforts within the identified target group; (3) select materials, curricula, and audiovisual aids relevant to intervention activities; (4) involve local media in programming efforts; (5) support and endorse primary care agencies; (6) recruit and develop qualified staff; (7) monitor and assess ongoing intervention activities of the Sub-Area I Health Education Consortium; (8) establish a model program for replication at other regional and national sites; and (9) contribute new knowledge techniques and services. The target group will consist of the total population (217,000) in a multicounty area, with primary emphasis on students in grades 7-8. For evaluation, the program will measure the significance of behavior and attitude change from in-

corporating smoking and alcohol risk management in the peer leadership counseling program, through pre- and posttests administered to 300-500 seventh and eighth graders (both experimental and control groups). One criterion for program success is a 1 percent reduction in smoking and drinking among 12- to 14-year-old participants by the end of the school year.

81P-0519
An Intervention Project to Deter Cigarette Smoking and Alcohol Abuse in Monroe County Children and Adolescents.
Indiana University, IN
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Intervention Project to Deter Cigarette Smoking and Alcohol Abuse is designed to (1) deter initiation of smoking and alcohol use among children and adolescents through a communitywide intervention and education program that alters perceptions of smoking and alcohol abuse as acceptable behavior patterns; (2) reduce the prevalence of smoking and problem drinking among university students, resulting in a more positive role image for youth; (3) develop a comprehensive educational program for local schools, using university students to instruct middle and high school students; (4) devise a community support system that provides weekly news releases to local media and materials to parent groups, local professional organizations, and health care providers; (5) apply DRUG (Decisions-Responsible Use-Guidelines) for use in student workshops; (6) reduce the prevalence of regular cigarette smoking in the target population so that it does not exceed 15 percent for university students and 26 percent for high school students; (7) assure the sales-weighted average tar content of cigarettes smoked by the target population does not exceed 15 mg; (8) reduce the prevalence of heavy drinking in the target population so that it does not exceed 25 percent for university students and 35 percent for high school students; and (9) ensure that the rate of problem-drinking behavior in a year will not exceed 25 percent for university students and 55 percent for high school students. The program will involve (1) instruction on peer influences on smoking behavior; health locus of control; perceptions of smoking as adult, sophisticated, sexually attractive, or intelligent behavior; aesthetic perceptions about smoking; smoking as risk-taking, curiosity-seeking, and sensation-seeking behavior; significant others as role models and role definers; and smoking as compensatory behavior; (2) base-line data collection as part of a countywide prevalence survey; and (3) specific data collection in housing units and classrooms on tobacco and alcohol use. The target group will include 5,000 students in 100 college housing units, and 1,400 students from 50 middle and high school classrooms. A yearly prevalence survey will be conducted each September for each target group. Each housing unit and school classroom participating in the program will be tested each year at the start and the end of the school year. Program interventions will be evaluated using a pre- and posttest comparison method and will also be compared to cohort controls selected from the general population.

IOWA

81P-0520
Health Education-Risk Reduction (HERR) Grant Project, Iowa.
Fries, D.
Iowa State Department of Health, Division of Disease Prevention, Third Floor, Lucas Building, Des Moines, IA 50319
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Iowa was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By September 1981 the State will identify and maintain an inventory of existing HERR programs. A written program definition will be completed; a survey questionnaire and explanatory cover letter will be developed; a mailing list of all private and public agencies, organizations and businesses to be surveyed by mail will be completed; and questionnaires will be collected from all known HERR programs and services existing in the 99 Iowa counties. By October 1, 1981, a categorical breakdown list of those programs and services will be available upon request at no charge. Program staff will inform agencies of the inventory's availability. The inventory will be used to assist communities to undertake an organized approach to risk reduction, to identify agencies collecting prevalence data, and to locate additional programs and services. By September 1981 the State will expand existing relationships and establish new working relationships

with all State agencies and private and public organizations within the State. The HERR program director will meet with a contact person from each State agency and all Iowa affiliates of national private organizations not previously visited. State agencies and departments will have opportunities to participate in HERR programs relevant to their purposes and functions. By September 30, 1981, the HERR program director will have established involvement with State agencies and departments having Federal grant activities (such as hypertension, diabetes, and nutrition) which complement the HERR program. A quarterly newsletter will be mailed to voluntary, local, private, and public agencies and organizations. By September 1981 the State will collect and compute prevalence and attitudinal base-line data determining Iowa's leading risk factors in communities taking an organized approach to risk reduction and in schools and businesses; provide communities with data collected by the State which involve their FY 1981 program including mortality by cause, prevalence data collected by various agencies, and hospital discharge data; and prevalence and attitudinal base-line data will be analyzed. Communities taking an organized approach to risk reduction will be asked to collect the minimal prevalence and attitudinal data by using the survey to be provided by the HERR program. The State will meet with the Department of Public Instruction's HERR Coordinator and request that proposed HERR school health programs use at least the Common Data Items recommended by CDC to evaluate the programs. The State will have at least five workplaces collecting risk factor data to support the need for employer assistance programs. During FY 1981 all private and public agencies collecting their own risk factor data will be asked to include the Common Data Items recommended by CDC for the HERR program. Attitudinal and prevalence data collected will be used to provide feedback for: defining community and statewide risk factor problems; establishing priorities for intervention programs and services for the State and community schools and businesses; program evaluation by pre- and postsurveys in communities undertaking an organized approach to risk reduction; and stimulating at least one workplace intervention which will use the Iowa Health Department's Awareness Program. During FY 1981 the State will identify existing sources of data relating to chronic diseases, morbidity, mortality, and the prevalence of risk factors to assist in the planning of improved surveillance. To achieve this, the staff will meet with the directors of the State Health Department's Division of Program and Planning and the Division of Data Processing to have an agreement to assist in the development of a plan to improve surveillance data collection and identify all State, local, and private agencies collecting risk factor data. The State will assess and review all data collected. A committee (consisting of one person from each of the following departments: Program Planning, Data Processing, Department of Transportation, and University data collection agencies) will be formed for the purpose of determining which data items might be added to improve chronic disease surveillance; providing an ongoing statewide mechanism to monitor changes in the burden of illness, diseases, and risk factor prevalence; and determining specific ways in which the information might be aggregated into useful surveillance information. During FY 1981 the State will encourage and assist Iowa communities to undertake organized approaches to risk reduction within a defined geographic target population including communities, schools, and businesses; announce statewide the HERR program characteristics and the availability of supplemental monies; describe to all interested agencies, organizations and communities the characteristics of the program (including a discussion of the "1990 Objectives for the Nation" and "Model Standards for Community Preventive Health Services"). Technical assistance and monitoring of funded intervention activities, including newly organized communities, will be done in cooperation with the Department of Public Instruction, Substance Abuse Program, and State University (under contract).

81P-0521
Health Education-Risk Reduction Program for Southeast Polk.
National Council on Alcoholism Education-Prevention (NCA), IA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program for Southeast Polk is designed to (1) educate children and adolescents about the health risks of alcohol abuse and smoking; (2) increase community cooperation in reducing the prevalence of smoking and alcohol use; and (3) train teachers to act as reinforcing agents of students' attitudes and behavior regarding alcohol use and smoking. To accomplish these goals, the program will conduct (1) teacher training to educate students regarding alcohol use and smoking; (2) a series of classroom presentations on alcohol use and smoking; (3) peer-facilitated groups examining alcohol use and abuse and smoking cessation; (4) presentations with Southeast Polk County parent-teacher associations; (5) presentations for civic and religious groups to heighten community awareness; and (6) pre- and posttests of a random sample survey group. The target group will consist of 2,700 students in grades 6-12 from 8 junior high and high schools in Southeast Polk County. Pre- and posttests will be administered to measure smoking and alcohol use attitudes and prevalence among 240 adolescents chosen in a random survey. Presentations to community groups will also be evaluated.

81P-0522
Iowa Fitness and Health Program.
Iowa State Department of Health, IA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Iowa Fitness and Health Program is designed to (1) reduce lifestyle-engendered illnesses through an employee health promotion program that involves at least 30 percent of the department of health's employees, and (2) encourage smoking cessation, hypertension control, physical fitness, nutrition education, weight reduction, stress reduction, and alcohol abuse reduction, and produce measurable changes in related behavior, knowledge, and attitudes. To accomplish these goals, the program will offer (1) employee health promotion activities that focus on smoking, nutrition, obesity, exercise, hypertension, and alcohol abuse; (2) a risk appraisal tool for confidential personal health assessment; (3) a questionnaire to measure prevalence of behavior, attitudes, and knowledge of risk factors in each program component area; (4) promotional and project-specific materials for intervention activities; (5) informational and educational materials on each risk factor, and peer liaisons to follow progress of individual program participants; (6) exercise for selected employees for at least 15 minutes, three times each week; (7) nutrition activities for selected employees that involve eating something daily from six major food groups; (8) publications to encourage peers and family as support groups; and (9) lunch-and-learn sessions to reduce stress. For evaluation, a survey will measure behavior, attitudes, and knowledge in the priority intervention areas.

81P-0523
Iowa Health Promotion-Risk Reduction Program.
Johnson County Board of Health, Johnson County Health Department, Iowa City, IA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Iowa Health Promotion-Risk Reduction Program is designed to (1) provide 2-hour inservice programs to educate teachers about alcohol, community resources, referrals, and prevention; (2) educate teachers in the objectives to be presented to children and adolescents about alcohol, values clarification, decision making, communication, and parent-child relationships; (3) emphasize the American Cancer Society's Network Series for Fifth Grade; (4) review and rewrite the Iowa Department of Public Instruction's recommended curriculum level II on alcohol (alcohol and other drugs) to specifically suit the project's needs, i.e., to teach the physiological, sociological, and psychological behaviors related to alcohol; (5) conduct a smoking prevention program for junior high students; (6) review and rewrite the Iowa Department of Public Instruction's curriculum level III on alcohol (alcohol and other drugs) to suit the project's needs; and (7) provide a stop-smoking program for parents and teachers in the schools. Each fifth and seventh grade class will receive 10 hours of instruction on alcohol and 5 hours on smoking. The health educator and the alcohol education and prevention facilitator (EPF) will familiarize the health teachers with the curriculum. The educator and facilitator will co-teach with the health teacher at each school. The EPF will train faculty and staff from 15 elementary schools and 3 junior high schools in the Iowa City district on general aspects of alcohol use. The health educator, trained as a facilitator by the American Cancer Society, will conduct smoking cessation clinics for parents and teachers who have or teach children or adolescents at the participating schools. The target group will include 603 junior high school students in 3 schools. For evaluation, students will be pre- and posttested on their attitudes, knowledge, and behavior in regard to alcohol and cigarette use and abuse.

81P-0524
Pocahontas-Calhoun Counties Health Promotion-Risk Reduction Program.
Iowa State Department of Health, IA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Pocahontas-Calhoun Counties Health Promotion-Risk Reduction Program is designed to (1) assess community behavior patterns using an attitude scale that reflects behavior change; (2) increase awareness and knowledge of the health hazards of smoking, alcohol abuse, obesity, stress, and hypertension by initiating school- and community-based programs that utilize existing community agencies, with results to be measured by attitudinal surveys; (3) reduce the incidence of smoking and alcohol consumption, with results to be measured by presurveys and postsurveys; and (4) allow young people to assess and develop a lifestyle that positively affects their health through providing peer programs offered by the American Cancer Society, the Iowa Lung Association, and the Iowa Department of Public Instruction. To accomplish these goals, the program will (1) assess lifestyle and behavior patterns to determine program effectiveness as related to alcohol and smoking; (2) conduct pre- and posttests of lifestyle and behavior patterns; (3) conduct programs in four schools, using existing community agencies to in-

crease awareness and knowledge of health hazards due to smoking, alcohol abuse, obesity, stress, and hypertension; (4) conduct onsite visits and surveys in schools to obtain data on incidence of alcohol use and smoking; (5) initiate "I'll Never Smoke" programs in grades 6-8, and "I Quit" programs in high school; (6) institute the "Peer Helper Program" in schools, using consultants and educational materials to decrease alcohol use; (7) coordinate and increase the use of cancer information materials within the community; (8) locate prenatal and Lamaze classes to introduce risks of alcohol and smoking during pregnancy; (9) use mass media techniques to publicize health hazards; (10) promote utilization of existing public health clinics; and (11) implement preventive health services. The target group includes students in grades K-12 in four schools in two counties. For evaluation, assessment of lifestyle and behavior patterns as they affect risk factors will be completed through a random sample in May 1981. An advisory committee will evaluate common data items in the program and assess certain factors related to health behavior (predisposing factors, such as knowledge, values, beliefs, and attitudes; enabling factors, such as health-related skills and resources; and reinforcing factors, such as family, peers, and teachers).

KANSAS

81P-0525
Health Education-Risk Reduction (HERR) Grant Project, Kansas.
Lockhart, V.
Kansas Department of Health and Environment, Forbes Field, Building 740, Topeka, KS 66620
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Kansas was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction All communitywide HERR activities will be inventoried and cataloged, and a system developed for updating this inventory every 6 months. School health education personnel will develop and maintain a statewide inventory of school HERR activities. An information communication network will be developed with the following groups and organizations, all of which have an interest in HERR programs: Governor's Council on Fitness; Kansas Public Health Association; Kansas School Health Association; Kansas Lung Association; Kansas Cancer Society; Kansas Heart Association; Cooperative Extension, Kansas State University; Department of Health, Physical Education and Recreation, Kansas University; Kansas Medical Society; Kansas Hospital Association; Voluntary Effort in Kansas; Kansas Blue Cross-Blue Shield; Menninger Foundation; Kansas University Medical Center; Kansas Association for Retarded Citizens; March of Dimes; Alcohol and Drug Abuse Programs, State Department of Social and Rehabilitation Services; Kansas Regional Perinatal Care Program; Kansas Red Cross; Kansas Obstetrical and Gynecological Society; Kansas Nurses Association; and State Department of Education. School health education personnel will develop a statewide school health education communications network among health and education programs. A consistent method of collecting and processing risk factor data will be in place. Technical consultation will be available to local risk reduction projects in order that data collection will be standardized across the State. Technical assistance will also be provided to schools and communities in collecting risk factor data on schoolchildren. The State will develop a statewide system of surveillance of risk factors as per CDC-recommended Common Data Items. Possible sources of risk factor surveillance data include: Bureau of Vital Statistics--mortality and morbidity data; newborn screen for selected genetic factors--Bureau of MCH; Cancer Registry--University of Kansas Medical Center; early childhood health assessment programs--local health departments; adult screen--local health departments; adult screening--Early Intervention Program; water pollution data--Division of Environment; air pollution data--Division of Environment; blood pressure screening--Kansas Heart Association; physical fitness assessments--YWCA's and YMCA's; occult blood screenings--Kansas Cancer Society; genetic counseling centers; occupational hazards--Division of Environment; Blue Cross-Blue Shield "cause of hospitalization" and medical reimbursement data; school immunization data--Bureau of Epidemiology; school district health data; school accident reports; traffic accident mortality--Kansas Highway Patrol; local HERR intervention projects; and data from PLUS programs. Other sources include (1) a questionnaire to random sample students, teachers, administrators, and other school officials to determine health problems, self-defeating attitudes and behaviors, and health education needs; (2) personal interviews to supplement questionnaires given to individuals above (not to the exclusion of local agencies, community workers, community based organizataions, local industry, local health departments, and agencies, etc.); (3)

outpatient and emergency room records of hospitals, health center records, etc.; (4) interviews with private practitioners (M.D.); (5) data from school health nurses (K-12) school district health data; and (6) interviews or questionnaires given to a random selection of patients in a variety of settings, family health centers, clinics, hospital outpatients, and private physicians. The State will also assemble a departmental ad hoc committee to arrive at a concensus as to the types of risk factor data that can be collected. It will use the ad hoc committee to suggest new and innovative ways risk factor surveillance can be carried out. Technical consultation and services will be provided to communities undertaking risk reduction programs. State-level school health educators will visit local school health intervention projects at least quarterly to provide management consultation and to monitor progress of the projects. The Kansas Department of Health, Department of Education, and the Drug and Alcohol Prevention Section of Social and Rehabilitative Services will develop a health promotion training plan for school personnel. Also training will be provided to community-level providers of risk reduction programs.

81P-0526
Douglas County Model Community Prevention System: Adolescent Smoking and Alcohol Risk Reduction Project.
Douglas County Drug Abuse Council, Lawrence, KS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Douglas County Model Community Prevention System is designed to (1) develop, implement, and evaluate school- and community-based programs designed to deter children and adolescents from smoking, alcohol use, and related problems through effective educational methods, and (2) reduce, in subsequent years, the countywide incidence and prevalence of smoking, alcohol abuse, and other precursors of preventable health conditions. To accomplish these goals, the program will (1) determine the prevalence of risk factors for the population of Douglas County through extrapolation from existing data and a planned survey; (2) provide a description of current and proposed commitments of effort to reduce the prevalence of risks in the community; and (3) implement three school-based intervention activities: (a) the Immediate Effects-Biofeedback Smoking Intervention Curriculum Package--an adaptation of the New Hampshire Lung Association Model, (b) peer counseling, and (c) smoking cessation clinics for the University of Kansas School of Education. The target group will consist of junior high and high school students of Lawrence (3,441), Eudora (365), and Baldwin (442), and University of Kansas students (25,173). For evaluation, pre- and posttests of knowledge, use, and attitudes will be administered.

81P-0527
Health Educational Risk Program to Deter Children and Adolescents From Smoking and Alcohol Use.
Butler-Greenwood Bi-County Health Department, KS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Educational Risk Program is designed to (1) foster the development, implementation, and evaluation of effective educational methods to deter smoking and alcohol use among children and adolescents; (2) reach young people before smoking and alcohol problems develop; (3) help children begin and continue patterns of health-related behaviors for optimal individual, family, and community health; and (4) help parents learn the facts about drinking and recognize their own drinking patterns and attitudes. To accomplish these goals, (1) the power of positive parenting course for parents of young children will be presented in eight 1.5-hour sessions, using handouts, films, demonstrations, and transparencies; (2) the New Hampshire Lung Association's biofeedback program, designed to stimulate a positive change in smoking habits of junior and senior high school students, will be used to demonstrate biofeedback techniques; (3) "Here's Looking at You," a multimedia approach using preformed kits on alcohol information for K-12, will be implemented; (4) the School Health Curriculum Project, a program for students in grades K-7 to instill good health habits, with an emphasis on the effects of smoking, will be presented; and (5) the Predisposing, Reinforcing, and Enabling Constructs in Educational Diagnosis and Evaluation (PRECEDE) model will be used as a framework in planning and evaluating the program. The target group will consist of 60,000 residents of Butler and Greenwood Counties, less than half of whom live in urban areas; the population includes 10,800 children. Evaluation data will be collected during May 1981 after the initial program implementation period, and will include process evaluation for review of use of resources and training of personnel; impact evaluation to reflect changes in participants' attitudes, values, knowledge, and behaviors; and outcome evaluation to identify long-term generalized results such as changes in morbidity patterns.

81P-0528
Health Education-Risk Reduction Birth Certificate Program.
Kansas City Department of Health and Environment, Building 740, Forbes Field, Topeka, KS 66620

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education Risk Reduction Birth Certificate Program will develop and initiate a health education-risk reduction model for the prenatal period and first year of life. Objectives include determining the prevalence of specific lifestyle risk factors among pregnant women in Kansas and identifying existing resources and methods for risk factor intervention. Resources needed will be specified, as will alternative methods for risk factor intervention. An educational model using available resources within the Department of Education and voluntary health agencies will be used. To meet these objectives, Kansas birth certificates will be studied for specified risk factors and supportive data including race, ethnic origin, and place of residence for all births. The target group consists of a selected number of pregnant women drawn from the top 20 counties listed in the Women, Infants, and Children Affirmative Action Plan. Evaluation will determine, by the close of the 5-year period, whether there has been a reduction in the occurrence of risk factors in the group.

81P-0529
Metropolitan Official Health Agencies of the Kansas City Area Bi-State Metropolitan Risk-Reduction Approach.
Metropolitan Official Health Agencies of the Kansas City Area (MOHAKCA), KS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Bi-State Metropolitan Risk Reduction Approach (for citizens of metropolitan Kansas City, including 3 counties in Kansas and 5 in Missouri, with a total population of 1,358,700) is designed to (1) help organize resources for risk reduction and develop model programs in selected settings; (2) begin incorporating the 1990 "Objectives for the Nation" into the program plans and policy statements of local health departments; (3) provide hypertension screening services to develop a common method of control; (4) gain the commitment of 4 health departments for the implementation of an areawide accident prevention program to begin in October 1981; and (5) effect sustained risk reductions and health behavior changes over a 5-year period, with emphasis on information and education in hypertension, smoking, alcohol abuse, obesity, stress, exercise, and automobile accident prevention. To accomplish these goals, the program will (1) convene a committee to develop common guidelines to implement new risk reduction and evaluate existing risk reduction activities, develop a survey for determining evaluation methods in local risk reduction activities, and report to MOHAKCA and other agencies; (2) conduct four meetings for MOHAKCA to discuss the risks of stress, uncontrolled hypertension, obesity, smoking, alcohol abuse, lack of exercise, and accidents; (3) gain the commitment of four health departments in planning a risk reduction activity; (4) provide a 1-day conference to design a strategy for support of risk reduction programs in the metropolitan area; (5) conduct a survey on resources and report results to MOHAKCA and other agencies; (6) hold quarterly meetings of MOHAKCA health officers and publish and distribute a monthly progress report to all members; (7) gain the commitment of all health departments in the National Health Promotion Media campaign; (8) conduct a conference for hypertension screening providers; and (9) develop an inpatient and a media plan for accident prevention. A self-reporting system, based on basic evaluation methodology, will be developed and instituted for all local health departments and the area risk reduction intervention providers.

81P-0530
Mid-America Health Promotion-Risk Reduction Program.
University of Kansas College of Health Sciences and Hospital, Department of Community Health, Kansas City, KS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Mid-America Health Promotion-Risk Reduction Program is designed to reduce the prevalence of smoking and alcohol use in three target populations (selected groups of black adolescents, Hispanic adolescents, and elderly persons) without increasing prevalence of other risk factors such as obesity, hypertension, sedentary lifestyle, stress, and accidents. To accomplish these goals, the program will (1) train and qualify medical, nursing, and allied health students to present programs within the community; (2) conduct a comprehensive smoking and alcohol intervention program at each of five target sites, utilizing the Kansas health department's PLUS (Program to Lower Utilization of Services) as a base; (3) conduct comprehensive intervention programs to develop the concept of total lifestyles for health; (4) train local adult and peer leaders who will continue interventions at the target sites indefinitely; (5) administer health hazard appraisals, the common data item interview schedule, and PLUS Lifestyle Profile and Fitness testing to determine the prevalence of health risk factors in the target populations; (6) administer appropriate questionnaires and surveys to determine predisposing health beliefs and attitudes within the target

populations that affect participants' accomplishment in intervention programs; and (7) identify sources of risk reduction programs neighborhood by neighborhood, and distribute to target populations a directory of risk reduction programs in metropolitan Kansas City. Product and process evaluation will be conducted. Success in achieving the specific aims for risk reduction will be assessed by comparing pre- and postprogram information from common data items on the developed questionnaire. Process evaluation will focus on organizational and administrative problems. Data will be used for evaluation and will be fed back into the system for further improvement in planning. Both phases of the evaluation will be planned in specific detail with consultants.

81P-0531
Project Youth-Days.
Topeka Public Schools, Topeka, KS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Project Youth Days is designed to (1) improve coordination and utilization of services provided by agencies offering assistance related to alcohol, other drugs, and smoking; (2) develop activities with students to deter children and adolescents from tobacco, alcohol, and drug use; and (3) develop activities with parents of schoolchildren served by the project to increase their knowledge about the hazards of tobacco, alcohol, and other drugs and strategies to use at home in dealing with substance abuse. A survey will be conducted to determine risk factor prevalence in the community, and objectives to reduce risk factors will be set. Activities will take place in and out of classrooms, in small groups, and on a one-to-one basis, by using materials provided by cooperating agencies. Teachers at all grade levels will receive instruction on the use of health education materials; coordinators will organize activities for parents, encourage their participation, and provide information to public and school media for publication. Also, a peer leader component will be developed, and weekend retreats will be held. The target group will consist of half of all students in Topeka public and private schools who choose to participate, a total population of 9,315. A process-impact evaluation plan will be conducted. Pre- and posttests administered during the year will be evaluated. A second measure of program effectiveness will be achieved by measuring whether criteria have been met by a randomly selected sample of program participants.

KENTUCKY

81P-0532
Health Education-Risk Reduction (HERR) Grant Project, Kentucky.
Brooks, R. W.
Department for Human Resources, Bureau of Health Services, 275 East Main Street, Frankfort, KY 40621
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Kentucky was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By February 1981 information obtained for the HERR inventory during FY 1980 will be used to compile a statewide directory of such services. In the following month, the directory's availability will be publicized, and it will be mailed to all agencies and organizations listed. By October 1981 the resource inventory will be updated for half the agencies listed. During 1981 5 more State agencies and 100 additional voluntary, public, or private agencies will be informed of the HERR program. All concerned State agencies will participate in reviewing, advising, and implementing the program. The HERR grant coordinator will meet quarterly with each agency involved in risk reduction activities. The HERR program will also develop a more clearly defined working relationship with the State Department of Education and the State Alcohol Unit. During 1981, using the CDC-recommended Common Data Items, the HERR program will provide assistance to communities in estimating or projecting the prevalence of risk factors. At least five State agencies will help the HERR program establish methods to determine prevalence factors. These data will be used to develop base-line statistics. During 1981 the data catalog of the Kentucky State Government will be reviewed to identify sources of information related to the risk reduction program. Questionnaires designed to identify sources of such data will be mailed to State agencies not listed in the catalog. By the end of the year, the applicant will review the data collected and determine which agencies report data relevant to risk reduction or surveillance. The State HERR program will work with 10 other State agencies to improve chronic disease surveillance. By January 31, 1981, 25 additional local agencies or organiza-

tions will be informed through written materials and meetings about organized approaches to risk reduction. Communities conducting organized approaches to risk reduction will be identified by using the HERR inventory and by contacting the appropriate agencies for information. During the year, seven communities conducting intervention activities will receive consultation and technical assistance from the applicant. By April 30, 1981, the HERR program will stimulate the development of five more intervention proposals from within the State.

81P-0533
Community Youth Health Education (CYHE) Project.
Lexington-Fayette County Health Department, Nutrition and Health Education, KY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Community Youth Health Education (CYHE) Project is designed to (1) identify and describe alcohol and tobacco consumption patterns in youths 6 to 16 years old in census tracts 9-11; (2) deter alcohol abuse and smoking among 20 percent of these youths; and (3) increase awareness and utilization of community resources. To accomplish these goals, the program will (1) design an interview schedule to identify quantity of alcohol and tobacco consumption; frequency of use; social situations associated with use; undesirable behaviors associated with use; knowledge, attitudes, and beliefs about effects of chronic use; and awareness and utilization of community programs and other resources; (2) administer the interview to 230 youths (a 10 percent sample) in the assigned districts, or at every 10th house on a street; (3) tabulate survey responses and prepare a summary; (4) produce and distribute 1,000 flyers through community agencies, and 75 posters explaining the program; (5) explain the program to clergymen, school counselors, and other community leaders, and to families they serve; (6) identify existing educational materials on alcohol and tobacco abuse and develop new materials for use with youths 6 to 16 years old, parents, teachers, and other community networks; (7) coordinate peer education sessions for 460 youths each year, including the recruitment of approximately 20 peer counselors; and (8) coordinate community development activities that involve 1,150 youths each year, offering on-the-job training. Evaluation will consist of (1) documentation and analysis of program activities, including number of distribution sites of educational materials for adults and youths; county agencies and leaders contacted about program services; youths recruited and trained as peer counselors, group discussions by peer counselors, and attendance at sessions; youths counseled individually; lectures, special projects, and people served in this way; alternate activities coordinated by program personnel and volunteers, and number of participants; and community development projects coordinated by project personnel and volunteers; (2) analysis of program impact on alcohol and tobacco consumption patterns; and (3) indepth case studies of 20 program participants, selecting 2 people between 6 and 16 years old each year.

81P-0534
Health Education-Risk Reduction Grant Program: Project to Deter Children and Adolescents From Smoking and Alcohol Use.
Cumberland Valley District Health Department, Manchester, KY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Grant Program is designed to (1) establish, validate, and publish base-line data on the prevalence of smoking and alcohol use among the target group members (18,230 10- to 19-year-olds in 4 southeastern counties); (2) organize community support; and (3) implement a standardized health education-risk reduction program in all area schools. To accomplish these goals, the program will (1) conduct a survey using the Centers for Disease Control's common data items; (2) contract with available personnel and agencies within the area to optimize resources; and (3) increase the use of personal choice behavior by role modeling, desensitization, peer cohesion, presentation of data, alternative behavior, development of realistic life and career goals, one-on-one counseling, identification, and decision-making exercises. For evaluation, a common data base will be established, and at the end of the program a survey using common data items will be made. In addition, a community advisory group will provide ongoing evaluation through recommendations and minutes of meetings; the target group will complete a one-page activity evaluation report; and project staff will report their reviews.

81P-0535
Health Education-Risk Reduction Program.
WEDCO District Health Department, Paris, KY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program is designed to (1) lower the risk of target populations (elementary and junior high school students, with a small group of adults

included because they are role models) in relation to the development of chronic disease; (2) provide a comparison of risk reduction intervention models through the demonstration and evaluation of a varied group of health education programs; (3) develop and utilize an effective tool with which to measure health habits and attitudes in grades 4 and 6; (4) identify clearly the prevalence of specific risk behaviors in given target populations; and (5) develop further and establish a cooperative understanding and working relationship among the various local agencies providing health education services. To accomplish these goals, the program will (1) provide four risk intervention models to target populations that utilize direct problem-oriented intervention, early preventive intervention, and role model modification: Component A--early preventive education model (coronary risk assessment and prevention) school-based program for grades 2 and 4; Component B--health hazard appraisal and a school-based component for the adolescent population; Component C--community-based parenting programs, and Component D--a community-based program for adolescents; and (2) evaluate the efficacy of these intervention models through collecting and contrasting outcome data. Evaluation will consist of (1) pre- and posttests of attitudes, knowledge, and health status where applicable for each component, and (2) staff and participant assessment.

81P-0536
Health Education-Risk Reduction Program on Smoking and Alcohol.
Northern Kentucky District Health Department (NKDHD), KY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program on Smoking and Alcohol is designed to (1) provide preventive health education programs to adolescents enrolled in prenatal and family planning clinics; (2) develop a data collection system about diseases associated with smoking and alcohol use; (3) reduce by 5 percent in the 1981-82 school year the percentage of students 12-18 years old in the Newport Public School System who consume alcohol more than once a week; (4) increase knowledge of students who participate in the alcohol education program by 10 percent; (5) develop an accurate system for monitoring the identity and frequency of retail and entertainment establishments that sell alcohol to minors; (6) reduce by 10 percent the number of adolescents enrolled in prenatal and family planning programs who smoke; (7) have at least 15 participants sign up for stop-smoking clinics every other month; (8) develop a support group format for adolescents who stop smoking; (9) reduce by 25 percent the number of adolescents enrolled in prenatal and family planning programs who drink alcohol more than once per week, and increase their knowledge about alcohol by 10 percent; (10) reduce by 10 percent the number of anemic adolescents enrolled in prenatal and family planning programs, and by 40 percent those who have an inadequate diet in regard to 1 of 4 food groups; and (11) have program participants answer, during second contact with a nutritionist, 3 out of 4 questions correctly concerning the importance and sources of iron. The program will be conducted through (1) a data collection system to assess diseases associated with smoking and alcohol use; (2) a system to monitor shifts in attitudes of students participating in alcohol education; (3) a system to monitor the identity and frequency of retail and entertainment establishments selling alcohol to minors; (4) stop-smoking clinics and workshops; (5) deep breathing and progressive muscle relaxation techniques to manage stress; (6) behavior modification techniques; (7) a support group format for adolescents who stop smoking; (8) a cognitive, affective, and behavioral curriculum for use in the public school system; (9) peer alcohol curricula; (10) peer education classes; (11) review of court records to evaluate establishments in violation of statutes regarding the sale of alcohol to minors; (12) bimonthly stop-smoking programs for prenatal and family planning patients; and (13) diet and anemia education. The target group will consist of 12- to 18-year-olds in Kenton and Campbell Counties who are at risk from alcohol use and smoking, including adolescents enrolled in prenatal and family clinics of the Northern Kentucky District Health Department. Process and impact evaluation will be conducted. Some objectives will be evaluated based on timely completion of method. An advisory and peer review committee will develop an evaluation design to measure achievement of objectives.

81P-0537
Health Education-Risk Reduction: Reduction of Smoking and Alcoholism in Children of Alcoholic Parents.
Seven Counties Service, Inc., Jefferson Alcohol and Drug Abuse Center, Louisville, KY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction program is designed to establish an early intervention and prevention program for 7- to 12-year-old children of alcoholic parents in Jefferson County (clients of the Jefferson County Alcohol and Drug Abuse Center), thereby decreasing the chance of

these children developing alcohol and chronic smoking problems in adult life. To accomplish this goal, the program will (1) conduct one outreach presentation annually to increase awareness of the problem and to ensure referrals to cooperating agencies; (2) identify children in need of intervention services; (3) develop and administer a pre- and posttest to measure knowledge levels and attitudes of all participants; (4) provide 20 series of group education and intervention programs with 12 sessions each, for a total of 240 sessions at a rate of 5 series per year for 200 children; (5) provide 800 family counseling sessions at a rate of 4 per family to 200 children and their families; (6) develop a system for internal evaluation; (7) provide followup to 90 percent of participants to evaluate overall effectiveness in reducing the rate of alcohol abuse and smoking; and (8) compile data for a final report. An evaluation will monitor the number of referrals to the program, administer pre- and posttests to measure knowledge and attitude changes among participants, compile monthly statistical reports, and conduct followup studies.

81P-0538
Preventing the Use of Alcohol and Tobacco in Children and Adolescents.
Bowling Green-Warren County Health Department, KY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Preventing the Use of Alcohol and Tobacco in Children and Adolescents is designed to (1) provide an organized approach to health risk reduction in Bowling Green and Warren County; (2) develop health education curricula for Head Start children and their parents or caretakers; (3) develop, offer, and evaluate a medical self-care course with emphasis on risk reduction, smoking cessation, and alcohol abuse referral, to be offered to an estimated 20 juvenile offenders; (4) train elementary school teachers working in schools with high minority enrollment to incorporate risk reduction activities into the health education curriculum; and (5) assess risk factors in the community and the target populations, based on common data items. To accomplish these goals, the program will (1) develop working agreements with approximately 20 voluntary, professional, educational, and consumer organizations serving the minority target population; (2) distribute a quarterly newsletter to organizations that are involved in risk reduction activities; (3) form a functioning advisory committee developed by the Minority Task Force; (4) form a committee of Head Start personnel and intervention project staff to derive a health education curriculum suitable for low-income and minority children 4-5 years old; (5) plan and conduct training for teachers; (6) develop an evaluation plan; (7) conduct an adult medical self-care course for parents or caretakers corresponding with the Head Start health education curriculum designed for their children, and administer a posttest questionnaire to the parents; (8) prepare a curriculum to meet the risk education needs of juvenile offenders enrolled in an education-rehabilitation program; needs will be determined through a survey of the students; (9) develop an evaluation plan to measure changes in knowledge, attitudes, behaviors, and skills of participants in the course for juvenile offenders; (10) offer the medical self-care course and smoking cessation classes for the juvenile offenders, and direct referrals to the Alcohol and Drug Program, as necessary; (11) conduct and evaluate an indepth 3-semester-hour workshop for 40 elementary teachers, through the Western Kentucky University Department of Health and Safety, on incorporating risk reduction activities into the health education curriculum; and (12) conduct an assessment of health risk factors in the community and the target populations, based on common data items. The target group will consist of Head Start children; minority children 9-12 years old; elementary school students; and juvenile offenders 13-17 years old. Emphasis will be on black youths in small urban and rural communities in Bowling Green and Warren County. Presently the scope of the evaluation is unknown; however, detailed plans will be developed for each component of the intervention project, and computer analysis and interpretation will be provided under a contract with the Western Kentucky University Department of Health and Safety.

81P-0539
Risk Reduction Program.
Bluegrass Regional MH-MR Board, Bluegrass East Comprehensive Care Center, KY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Risk Reduction Program is designed to (1) implement a cognitive and affective education program aimed at reducing alcohol and tobacco use; (2) provide training in the program to teachers; (3) provide an inschool alcohol and tobacco health education program in two counties; and (4) arrange and present education programs to community groups interested in health issues. To accomplish these goals, (1) the staff will offer 15-hour education modules in five junior high schools; (2) a health educator will be made available in Powell County to grades 3-6, and to the middle school and high school; (3) two teacher training workshops will be offered, one in each county; (4) two educational presentations to the communities in each of the two counties each year will be offered; and (5) the

programs will be made available to youth during summer months so that the target group can be reached in a different setting; attempts will be made to get at least 10 community groups in each county to cooperate in these outreach programs. In Fayette County, the target group will consist of 23,000 adolescents, 12-18 years old, although primary emphasis will be on junior high school students, 12-15 years old. In Powell County, the target group will be all students in grades 3 through 12. The program will be evaluated through impact assessment and cost outcome analysis. The instruments for these evaluative components have not been selected.

LOUISIANA

81P-0540
Health Education-Risk Reduction (HERR) Grant Project, Louisiana.
Goins, E.
Department of Health and Human Resources, Office of Health Services and Environmental Quality, P. O. Box 60630, New Orleans, LA 70161
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Louisiana was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. HERR programs and services will be inventoried by health region. This inventory will be distributed to funded intervention projects and other interested persons or agencies. Regional health councils will also be formed to enhance the collection and usage of inventory information. State agencies and departments will be involved in the HERR intervention activities relevant to their purposes and functions. Program goals, objectives and activities, and quarterly progress reports will be distributed to the appropriate State agencies. An opportunity will be organized for the State agencies to advise, review, or participate in HERR intervention projects. A technical assistance committee will also be organized. The technical assistance committee will recommend additions or improvement of CDC's Common Data Item instrument. Contracts for conducting the survey will be established with either the Tulane School of Public Health, PARA, Equifacs, or another organization. Appropriate procedures for acquiring sanctions, endorsements, or clearances will be provided by the State program director. The technical assistance committee will provide a compiled list of available morbidity and mortality data sources, and a list of State agency projects concerning risk factors of chronic disease. Identified State agencies and departments will be requested to collect additional data items. A data base system will also be recommended to private and public agencies. The characteristics of a community undertaking "an organized approach to risk reduction" will be defined at regional meetings.

MAINE

81P-0541
Health Education-Risk Reduction (HERR) Grant Project, Maine.
Miller, E.
Maine Department of Human Services, Bureau of Health, State House, Augusta, ME 04333
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Maine was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The State HERR program will refine and update its computerized and retrievable inventory of existing HERR programs, resource services, and sources of technical assistance. An abridged version of the inventory will be available for participants in the process. The Department of Human Services library will begin to assume new responsibilities as a resource for printed and audiovisual resources specific to risk reduction. Requests for quantity amounts will be referred to the appropriate organization or agency. A model catalog of sample risk reduction printed material will be developed and promoted for use in all health science and public libraries. The library's technical information sources on HERR, oriented

towards practitioners, will also be expanded. Major health education resource centers and university programs throughout the country will be surveyed in order to determine those reference materials essential in developing a quality library collection. The State HERR program will continue to publish its newsletter in order to expand knowledge of the inventory. Also to increase public knowledge of risk reduction programs and services, the HERR State program will utilize the health departments toll-free information and referral line. This line will also be used to provide information on problem areas such as smoking and hypertension. Specific consumer guides will be constructed from inventory information on the areas of smoking cessation, nutrition education services, and cardiovascular fitness programs. The State HERR program will use the inventory to identify gaps in program areas, services or resources, focus program development, initiatives, uncover effective projects, identify useful resources, provide an information base, and identify potential cooperative efforts. The State HERR staff will continue to work cooperatively with various groups and organizations. They will continue to work with "Maine Health Agencies Against Smoking During Pregnancy" in program development and evaluation. They will work with the State Office on Alcoholism and Drug Abuse Prevention, the State Police, and local educational agencies and radio stations to reduce alcohol-related motor vehicle accidents involving males 17-24. Through the school health education project, the HERR program will maintain and improve its consultative and technical assistance relationship with the State's educational system. Specific attention will be focused on smoking and alcohol use among children and adolescents. Hypertension control, smoking cessation, weight control, and patient education programs in rural health centers will receive assistance in evaluation and program refinement. The State HERR program sees this as a very important working relationship since in rural areas hospitals are the centers for health education as well as primary care. The HERR project will work with University of Maine at Farmington to develop three continuing education programs to assist practitioners in addressing risk reduction issues. Cooperative efforts between HERR activities will be rewarded and reinforced through featured stories on effective programs in the "Maine Health Promotor Newsletter." Direct or indirect provision of training or consultation will be provided to HERR programs. The team approach to project monitoring and evaluation service arrangements, made with University of Maine as a part of the intervention grant process, will also serve as a means for developing more formal cooperative relationships. The State HERR program will work with at least two health centers and two community hospitals by providing assistance in survey design and analysis. From this, the degree to which volunteer services in each of these settings is useful in conducting prevalence surveys will be determined. If this is effective, the statewide network of health centers, community hospitals, and community nursing agencies will be considered for assistance in future project years. The applicable components of the instrument developed for use will be the ones given preference in locally conducted surveys. With approval from the Maine Hospital Association, the 100 percent hospital discharge data will be utilized to gather hospital-specific rates for smoking during pregnancy; this process will be documented and assessed for its utility in other special risk factor studies. The uniform accident reporting system of the State Police will be used to identify high risk communities for alcohol-related accidents and to monitor seat belt usage in reported accident situations. Incidence-based data available as a result of a new statewide fire reporting system will also be used. The State project will survey medical care practices in the State to determine the extent to which risk factor data could be collected. Special attention will be given to rural health centers, health maintenance organizations, group practices, community nursing agencies, and practice management systems. During the next year, the HERR program will try to integrate risk appraisal into the current data collection effort of other health department programs such as WIC and the statewide Adult Health Assessment Program. In collaboration with the school health education project, the HERR program will initiate a statewide smoking prevalence study among a representative sample of 6th, 8th, and 12th grade students. Plans for Fiscal Year 1981 include to determine which existing sources of morbidity data can be used to become par

81P-0542
Safe Wood Heating Project.
Maine Department of Human Services, Bureau of Health, State House, Augusta, ME 04333
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Safe Wood Heating Project is designed to reduce morbidity and mortality associated with the unsafe burning of wood as fuel. Objectives are to (1) increase the capability of the Bureau of Health's Risk Reduction Project to conduct accident prevention and wood-heat safety education programs; (2) establish, in conjunction with the Kennebec County Cooperative Extension Services' Community Energy Home Project, at least two safe wood-burning model homes to showcase optimum wood-heat safety practices and to serve as focal points for educational programming; (3) develop and promote a wood-safety learning activity packet in cooperation with the staff of the Department of Educational and Cultural Services and the

School Health Education Project; (4) test the effectiveness and acceptability of a variety of methods for wood-burning safety education; and (5) coordinate the Risk Reduction Project's efforts with those of the State Office of Energy Resources, the State Fire Marshall's Office, the statewide offices of the Cooperative Extension Service, and local fire departments. With assistance from the Cooperative Extension Service, the Office of Energy Resources, the University of Maine, and wood-stove manufacturers and distributors, all wood-burning safety education material will be cataloged and assessed for utility in the project's three principal target areas, i.e., chimney safety, stove selection and installation, and proper stove operation. Arrangements have been made which will allow this project to make maximum benefit of the project initiated by the Kennebec County Cooperative Extension Service. Sites have been selected to be used as demonstration centers for imparting information and education. With the assistance of the School Health Education Project staff at the University of Maine's Health Education Resource Center, a safe wood-burning activity packet for inclusion in the school curriculum will be developed and promoted through a statewide poster or science demonstration project contest. Self-instructional programs will be developed for use by public health nurses during home visits, at well-child clinics, and at adult health screening programs. The use of the media will be evaluated for a creative approach to chimney safety and stove operation, maintenance, and installation. Contact will be maintained with the major resources and organizations in the State. A number have assisted in providing documentation for this proposal. The target group will consist of all residents of Kennebec County, although a number of educational activities will be statewide in focus. The Safe Wood Burning Centers will be evaluated in Kennebec County as part of the overall Community Energy Home Project. In addition to measuring changes or significant differences in knowledge, attitudes, and practices among participants, the effectiveness and acceptablility of this demonstration model approach will be assessed.

MARYLAND

81P-0543

Health Education-Risk Reduction (HERR) Grant Project, Maryland.

Mariotti, N.

Health Education Center, Department of Health and Mental Hygiene, 201 West Preston Street, Baltimore, MD 21201

Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Maryland was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By January 1981 the State plans to complete an inventory of health education risk reduction programs and services conducted by local health departments, voluntary agencies, State agencies, health maintenance organizations, community colleges, public and nonpublic elementary and secondary schools, and hospitals, and to integrate information obtained into the Baltimore City Health Department inventory. By June 30, 1981, the State will complete the statewide inventory by surveying industries, employee programs, proprietary programs, universities, 4-year colleges, parks and recreation departments, social service organizations, churches and religious organizations, and mass media. By January 31, 1981, information about the goals, objectives, and activities of the HERR program will be distributed to the following professional associations: Medical and Chirugical Faculty, Maryland League for Nurses, Association of Counties, Association of Local Health Officers, Association of School Health Nurses, Maryland State Teachers Association, and the Council of Directors of Community Health Nurses. By March 19, 1981, opportunities for sharing of program information and joint activities will be identified and explored with the following State agencies: Department of Natural Resources, Department of Employment and Social Services, Department of Corrections, Office of Aging, Department of Transportation, and the Cooperative Extension Service. By April 30, 1981, an information and resources sharing conference will be held with local grantees and potential grantees. By October 1980 the State plans to determine those data sets that include behavioral risk factor data that are consistent with the CDC's recommended Common Data Items. By February 1981 an expert ad hoc group will complete recommendations, with review and comments by the Maryland Core Data Group, for improved and standardized statewide data on behavioral risk factors for chronic diseases. In early FY 1981 the State plans to conduct a training session for local intervention projects on establishing risk factor prevalence. During FY 1981 the Health Education Center, Department of Health and Mental Hygiene, will enhance chronic disease surveillance in the State by extending the capacity of current systems to provide data on

the prevalence of risk factors. The staff of the risk reduction project will attempt to bring about changes by developing positive working relationships with programs primarily through giving and receiving consultation, technical assistance, and training; by providing financial support; or by purchasing services such as data analysis. By May 30, 1981, two orientation and training programs will have been conducted with grantees to assist them in meeting the requirements of the grant and developing their programs. By September 31, 1981, two training events for interested local agency personnel to learn how to develop an HERR program or integrate it into their current programs will be completed. By November 30, 1980, a meeting will be held with Eastern Shore organizations (health, education, business, etc.) to explore the feasibility of and formulate a plan to develop a health education network of resources (joint with the HSA) to support program development. During FY 1981 a special effort, the Talbot County Demonstration Program strategy, will involve three components: (1) development of the capability of the Talbot County Health Department to provide risk reduction services and involve other department programs, e.g. high blood pressure and family planning, by referral mechanisms for risk factors; (2) involvement and training of health professionals in the community to prompt and support their patients' risk reduction efforts; and (3) engagement of the community in organizing and participating in programs to reduce the risk of members of the general public to chronic diseases.

81P-0544
Adolescent Alcohol Use and Smoking Cessation Program.
Baltimore City Area Health Education Center, Inc., Baltimore, MD
Funding Source: Center for Health Promotion and Education (DHHS, CDC) Atlanta, Ga.
1980 - Continuing.

The Adolescent Alcohol Use and Smoking Cessation Program is designed to (1) foster a reduction in the prevalence of alcohol and tobacco use among adolescents in the target group (10- to 18-year-olds in the Lexington, Shipley Hall, and Lexington-Poe areas of Baltimore City), and (2) develop a comprehensive community-based educational program which, through trained community caregivers, provides adolescents with the knowledge, understanding, and support to choose constructive behaviors as alternatives to alcohol and tobacco use. To accomplish these goals, the program will (1) educate 40 community caregivers in the techniques of primary, secondary, and tertiary prevention relating to drinking and smoking; (2) provide health information concerning alcohol and tobacco to adolescents in group sessions; (3) provide an intervention program for those adolescents found to have a smoking problem; (4) increase the use of existing community programs on substance abuse; (5) develop and implement a system for synergizing health education resources with the Baltimore City School System; (6) use appropriate evaluative instruments; and (7) provide an intervention strategy on alcohol use, to be taught by faculty of the Alcohol and Drug Abuse Program, University of Maryland School of Medicine. For evaluation, counselors will be surveyed to gather base-line information on their knowledge and attitudes toward the target behaviors, as well as their actual alcohol and smoking-related behavior. Following the training program, survey instruments will again be administered to assess the cognitive and attitudinal impact of the curriculum. The entire group will be administered the survey instruments prior to intervention. Data will be collected from community caregivers and from adolescents at inception of intervention and again 1 and 2 years later. Pre- and posttests will calculate the mean percent change in knowledge and attitudes.

81P-0545
Baltimore City Health Education-Risk Reduction Project.
Baltimore City Health Department, Bureau of Health Education and Information, lll N. Calvert Street, Baltimore, MD 2l202
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atianta, Ga.
1979 - Continuing.

The objectives of the Baltimore City Health Education-Risk Reduction (HERR) Project include a reduction in the rate of heart disease, cancer, and stroke within the project area and the development of a comprehensive risk reduction program coordinated throughout Baltimore City. Specifically, the project aims to (1) establish an office of Risk Reduction and Wellness within the Bureau of Health Education and Information to coordinate health risk reduction programs and provide support services to the project area; (2) develop an inventory of the operational health risk reduction programs being operated in the project area; (3) develop a local health education resource center that provides educational materials, hardware, and consultation to health care facilities, communities, and voluntary agencies participating in risk reduction; (4) assess the inclusion of risk reduction instruction within schools in the project area and modify the health education curriculum; (5) develop and pretest the basic training package in risk reduction for nursing staffs of community health centers and ambulatory care settings; (6) initiate the support system for counseling respondents from the

health hazard appraisal media campaign; and (7) encourage participation in the health hazard appraisal program and in HERR activities. The project is divided into four components: (1) a management component responsible for resource coordination and evaluation, (2) a community education component that utilizes the existing community or ethnic structure in implementing risk reduction, (3) a mass media component that measures the impact of neighborhood and citywide campaigns on the target population, and (4) a professional training component that will enable the health staff to conduct risk reduction counseling. The project area is a low-income, multi-ethnic community whose 4,000 residents include native Americans, blacks, East Europeans, Hispanics, and Mediterraneans. A telephone survey will be conducted to determine whether the project has had any impact on the population within the project area. Consultation services for this evaluation will be procured from the Division of Health Education, Johns Hopkins School of Hygiene and Public Health.

81P-0546
Smoking Risk Reduction for High Risk Populations.
American Lung Association of Maryland, MD
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Smoking Risk Reduction for High Risk Populations is designed in the first of 2 years to (1) reduce the prevalence of smoking by 20 percent among pregnant women, and reduce the number of cigarettes smoked by an additional 50 percent; (2) implement the Smoking and Pregnancy Counseling Protocol with at least 50 percent of the smoking women; (3) increase knowledge of the health effects of smoking in relation to the use of oral contraceptives in 5,000 women using oral contraceptives; (4) prevent the initiation and reduce the prevalence of adolescent smoking in the East Baltimore Medical Plan catchment area; (5) improve the ability of program participants to understand the dangers of smoking; (6) cause program participants to perceive smoking behavior more negatively and nonsmoking behavior more positively; and (7) decrease the incidence of smoking among the adolescents served by the East Baltimore Medical Plan. To accomplish these goals, the program will (1) counsel a randomly selected pilot group of at least 100 pregnant patients who are smokers, using the Smoking and Pregnancy Counseling Protocol; a training program will be established for prenatal health care providers; (2) develop, pretest, reproduce, and distribute to women using oral contraceptives materials describing the health effects of smoking and using oral contraceptives; and (3) counsel adolescent pregnant women using the Smoking and Pregnancy Counseling Protocol, collect data on cigarette consumption, work with staff members of the Adolescent Services Program to expand emphasis on smoking, design a program on smoking attitudes to be presented by adolescents to students in grades 4-6, establish a pilot program, evaluate the program, and recruit for and implement a smoking cessation clinic for adolescent smokers. For evaluation of the first step, pretests, posttests, and telephone interviews of participating patients will be conducted, health care providers will be evaluated, and followup evaluations will be conducted. For the second step, a 3-month followup evaluation of health care providers will determine utilization of materials. For the third step, data will be evaluated, participants will be pre- and posttested to determine attitudinal and knowledge changes, and the smoking cessation clinic will be evaluated using the American Cancer Society's evaluation component for attitudinal change.

81P-0547
Smoking Tobacco and Alcohol Abuse Prevention Program in Howard Public Schools.
Howard County Health Department, MD
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking Tobacco and Alcohol Abuse Prevention Program is designed to (1) equip students to resist social pressures; (2) inform students about the reason for not smoking and abusing alcohol; (3) reduce smoking by eighth grade students by 50 percent as compared with the rate for 1978 (long-term); (4) reduce smoking by 10th grade students by 40 percent as compared with the 1978 rate (long-term); and (5) reduce alcohol use by 10th grade students by 20 percent as compared with the 1978 rate (long-term). The program will be presented during one class period for 3 successive days, and four followup sessions will be held over the remainder of the school year. Six pilot schools will be divided into three groups of two schools each; one group will be a control. Videotapes will be taken of peer leaders working with one of the two experimental groups during implementation of the social pressures curriculum. Videotapes will then be used to supplement the efforts of peer counselors working with the other experimental group. Peer counseling, role playing, and discussions based on pressures to smoke and drink will be featured, and assertiveness training and decision-making skills will be taught as alternatives to rebelliousness. Also, films demonstrating the effects of alcohol will be shown; individual, family, and group counseling will be offered; and biofeedback machines will be used. Family and community involvement will be encouraged

through meetings and brochures mailed to parents. The target group will include students in grades 7-8 from six middle schools. Approximately 2,000 seventh graders will be offered the program on smoking, and 2,032 eighth graders will be offered the program on alcohol abuse prevention. For evaluation, the same questionnaires will be administered 6, 12, 18, and 24 months after initiation of the program to measure change in smoking and alcohol use. School and parent reports of smoking and alcohol use will be utilized, and saliva and breath tests will be repeated.

MASSACHUSETTS

81P-0548
Health Education-Risk Reduction (HERR) Grant Project, Massachusetts.
Hyde, J.
Massachusetts Department of Public Health, Division of Preventive Medicine, 600 Washington Street, Room 705, Boston, MA 02111
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Massachusetts was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. Of the six Health Systems Agencies (HSA's) in Massachusetts, four have compiled, or are completing, inventories of HERR programs in their areas. Using the inventories from these four HSA's and data collected in the other two regions, an inventory will be compiled, published, and distributed to various public and private agencies. The Department of Health has established a Task Force on Prevention, whose members are from the public, private, and voluntary health sectors. This task force will establish communication among various types of health agencies as well as planning and cooperative relationships. A subcommittee of the task force will review the prevention component of the 1979 State Health Plan. In conjunction with Connecticut, Rhode Island, and New Hampshire, the Department will also develop a public education and informational campaign on second-hand smoke. The State will strengthen the Massachusetts Task Force on Prevention by establishing subcommittees to provide technical assistance and guidance and to promote HERR activities, and will monitor and evaluate the HERR programs that CDC approved for FY 1981. Massachusetts will compile data on risk factor prevalence in relation to diet, smoking, and exercise. Several observational surveys of smoking behavior will be conducted, and the resulting data will be analyzed. Attitudinal and behavioral self-report data will be obtained through telephone surveys, and a yearly report, integrating all risk factor prevalence, mortality, and morbidity data will be submitted to the Task Force on Prevention. By using population estimates supplied by the Office of Health Statistics, the Department will develop morbidity data. Standardized mortality ratios will be compiled using mortality data from the Office of Health Statistics. A yearly report integrating all risk factor prevalence, mortality, and morbidity data will be submitted to the Task Force on Prevention. Because Massachusetts has many community-based agencies with potential for conducting intervention activities, the Department of Public Health will conduct workshops to help them apply for funding and to deliver services effectively. The Department will design and conduct these workshops. After the workshops, there should be an increase in the number and quality of HERR proposals.

81P-0549
Adolescent Alcohol and Smoking Prevention Project.
South Cove Community Health Center, Inc., MA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Adolescent Alcohol and Smoking Prevention Project is designed to (1) conduct programs for Asian adolescents in the school and community to promote a better understanding of smoking and alcohol abuse and to facilitate positive behavioral change; (2) increase Chinese parents' awareness of the health hazards of tobacco and alcohol abuse and help them understand their role-modeling influence upon their children; and (3) promote awareness in the Chinese community of the health hazards of tobacco and alcohol abuse and enlist community support for the prevention program. In schools that contain bilingual classrooms, the program will consist of a series of 40-minute sessions presented during health class periods for groups of 8-25 students. In schools that do not have bilingual classrooms, the program will be presented during general assembly, activity period, or in an Asian club setting. The series will also be offered in neighborhood youth centers and in the South Cove health center. For schools

that do not use the 12-session series, a 2-session miniseries will be offered to stimulate participants to join the longer series where it is offered. A variety of educational formats will be used, including lectures, group discussion, role playing, activity-game exercises, and films and slide presentations. For the second objective, a series of two lectures and discussions will be used, incorporating slide presentations, group discussion, role playing, and reading materials. For the second objective, the program will distribute bilingual articles throughout the community; publish in the health center newsletter articles on tobacco or alcohol consumption; dispense information at community festivals; broadcast programs relating to tobacco and alcohol over the health center's weekly health education radio program, which reaches Chinese communities in Boston and New York; and contact community agencies to enlist their support. Adolescents and parents will be pre- and postested, and other evaluations will measure class attendance; distribution of bilingual articles pertaining to health, tobacco, and alcohol; and number of community agencies contacted. The target group will consist of 700 Chinese Boston public school students 13-18 years old, parents of Chinese adolescents, and the Chinese community in general. Evaluation will be developed by a program coordinator, and simple instruments such as pre- and posttests will be administered to participants.

81P-0550
Alcohol and Smoking Awareness Program for Adolescents.
Mount Auburn Hospital, Community Health Education Department, Cambridge, MA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Alcohol and Smoking Awareness Program for Adolescents is designed to (1) train 60 teachers to conduct alcohol and smoking intervention programs for the target population (3,000 high school students in Arlington, Belmont, and Watertown); (2) compile a "training package" model that can be used in other communities; (3) reduce by 20 percent the proportion of students who smoke; (4) reduce the incidence of drinking among students; and (5) impart knowledge about the implications of substance abuse, teach values-clarification skills to aid students in making decisions regarding substance use, and elicit a commitment from each student to make at least one positive choice about the use of alcohol and tobacco. To accomplish these goals, the program will (1) design a teacher-training program with four phases: (a) conceptual and generic information on smoking and alcohol, in an 8-hour, 1-day workshop; (b) practice of alcohol education, in a 12-hour, 1-day session plus two biweekly sessions; (c) practice of smoking education, in 10 hours over five biweekly sessions; and (d) classroom implementation consultation, in 8 hours over four weekly workshops; (3) deliver classroom programs in 10-15 class periods (45 minutes each); and (4) create a comfortable climate for exchange of ideas and for clarification of values and feelings. For evaluation, pre- and posttests will be administered to three groups: one class following the full 10-week structured curriculum; one class receiving spontaneous instruction from a trained teacher, rather than the formal curriculum; and one control group, whose teacher was not involved in the training.

81P-0551
A Community Approach to Adolescent Smoking and Alcohol Prevention.
Lifeways-Health Promotion Resource Center for Western Massachusetts, Inc., 184 Northampton Street, Easthampton, MA 01027
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The goal of the Community Approach to Adolescent Smoking and Alcohol Prevention is to decrease incidence and prevalence of adolescent smoking and alcohol-related risk behavior through implementation of a community-wide program that will enable young people to carry out community risk reduction efforts. Towards that end, (1) participatory health education-risk reduction models will be piloted and tested in two settings, with a youth substance abuse advisory board providing leadership, community education, and advocacy before the introduction of participatory education into community programs and a mandatory health course at the high school level; (2) youth model programs will be incorporated in at least one traditional high school and one community program, and teachers will be offered inservice training to implement the high school-level mandatory health education course; (3) participatory risk reduction activities will be offered in community settings through information dissemination and staff training; (4) leadership will be developed for a support group and communications network for school and community staff involved in participatory health education activities; and (5) a "how-to" manual will be prepared for use in other communities. The project's focus will include but not be limited to smoking and alcohol abuse. Health values and attitudes favorable to prevention of abuse will be developed through a holistic approach to good health habits, decision-making skills, and improved self-image. Training and assistance will be given to young people who, in turn, will teach and advocate risk reduc-

tion programs. Specifically, (1) students at an alternative high school will act as health promoters for their community in action-oriented educational programs, including smoking and alcohol abuse prevention; (2) students appointed to a city-sponsored youth board will advise community leaders and educate community members on substance abuse problems and solutions from the point of view of adolescents; and (3) a health risk appraisal instrument will be introduced into the junior high curriculum. The target group consists of residents of the city of Springfield, Massachusetts, whose 1980 population projection was 166,090. Evaluation of this project will utilize both quantitative and qualitative techniques.

81P-0552
North Shore Employee Health Promotion Project.
North Shore Health Planning Council, Inc., MA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The North Shore Employee Health Promotion Project is designed to (1) organize 1 comprehensive model worksite health promotion program addressing multiple risk factors; (2) provide short-term technical assistance to employers to develop 10 additional worksite programs addressing at least 1 risk factor; and (3) evaluate the different methodologies of the 2 programs to determine the best way to use resources to reduce risks of premature death and disability and to improve the health status for specific target populations. To accomplish these goals, the program will (1) develop and implement one comprehensive multiple risk factor reduction program in the following stages: (a) develop criteria for site selection, (b) select the site, (c) distribute an employee interest inventory, (d) select participants, (e) implement program components, and (f) conduct evaluation interviews at program completion and 6 months later; (2) implement similar single-factor risk reduction programs at 10 worksites; and (3) evaluate programs by collecting data on participation, reduction of risk factors, subjective feedback from employees and employers, and analysis of job performance. The target group will consist of 700 employees of area businesses (200 employees in 1 comprehensive program, 50 employees in ten 1-risk-factor programs). Contract evaluators will be hired to conduct interviews with the target group at the close of the program and 6 months thereafter to ascertain changes in risk factor levels.

81P-0553
Smoking and Alcohol Abuse Prevention Project.
735, Inc., Melrose, MA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Abuse Prevention Project is designed to (1) improve by 12 percent the attitudes of participants (all students in grades 5-8 in Melrose, Wakefield, Stoneham, and Reading, a total of 6,110) toward smoking and alcohol use and increase their knowledge of these substances and their effects by 35 percent; (2) improve the knowledge of parents who participate by 25 percent, their attitudes about teenage use by 35 percent, and their attitudes about general use by 15 percent; (3) improve the knowledge of teachers who participate by 30 percent, their attitudes about teen use by 45 percent, and their attitudes about general use by 15 percent; and (4) develop data and evaluation tools for gaining further information on prevalence, use, attitudes, intervention effects, and correlates of smoking and alcohol use. To accomplish these goals, 32 teachers (2 from each grade in each town) will be trained for a minimum of 6 hours in alcohol and smoking education and peer leader training. Peer leaders (30 from each of 4 towns), 2 opinion leaders in each classroom (496 in all), and 4 groups of parents in each town will also be trained. Grades 5-6 will employ, in four to seven teaching sessions, the CASPAR (Cambridge and Somerville Program for Alcoholism Rehabilitation) curriculum, and grades 7-8 will use a more sophisticated (10-session) CASPAR curriculum. A smoking prevention education curriculum (designed by McAlister) will be designed to (1) strengthen the students' commitment not to become dependent on tobacco, and demonstrate the overt and subtle social influences that encourage smoking; (2) demonstrate verbal or cognitive responses appropriate to various pressures, and encourage students to develop and present their own ideas on handling those situations; and (3) allow students to role play verbal responses to various inducements to smoke. A researcher will be responsible for the development, compilation, and reporting of all data. The base-line data will be developed through a comprehensive preproject survey and through pretraining surveys.

81P-0554
Tewksbury Program for Reducing Smoking and Alcohol Abuse.
Tewksbury Board of Health, MA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Tewksbury Program for Reducing Smoking and Alcohol Abuse is designed to (1) foster a 20 percent increase in the information students possess regarding the effects of smoking on health, and an 8 percent gain in positive be-

liefs and attitudes regarding smoking; (2) enable students to exhibit a 20 percent gain in the ability to identify psychosociological factors that influence the rejection, initiation, or continuation of smoking behavior; (3) promote a 25 percent increase in the information students possess regarding the nature of alcohol and the scientific facts of its effects on the mind and body, and a 10 percent gain in positive beliefs and attitudes regarding alcohol use; (4) have parents exhibit a 30 percent increase in their knowledge of the basic communication skills required to help children learn to make informed decisions about alcohol use, and a 30 percent increase in the level of accurate information they possess about alcohol; and (5) enable teachers, parents, and students to identify persons, including themselves, who have problems with their own drinking or the drinking of a close relative or friend. To accomplish these goals, the program will (1) administer the CASPAR (Cambridge and Somerville Program for Alcohol Rehabilitation) "Decisions About Drinking" (grades 9-11), 10 lessons per grade level; (2) administer the CASPAR "Revised Student Inventory: 1979"; (3) administer "How to Talk With Children About Drinking," and its companion evaluation instrument in four 2-hour workshops; (4) offer life skills training in 10-12 class sessions; and (5) offer a smoking modification program for adolescents. The target group will consist of 1,800 students in grades 8-11 and their parents. The community at large will be reached through certain aspects of the program. Pre- and posttest instruments will accompany each element of the program.

MICHIGAN

81P-0555
Health Education-Risk Reduction (HERR) Grant Project, Michigan.
Fong, S. S. N.
Michigan Department of Public Health, Office of Health Education, 3500 N. Logan, P. O. Box 30035, Lansing, MI 48909
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Michigan was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By September 15, 1981, the State plans to complete an inventory of existing HERR programs and services in three selected communities; to utilize data collected from survey as a tool for community organization, coordination, and planning purposes by March 15, 1982; to update information in the inventory through resurvey of the same communities in subsequent years by September 15, 1982; to utilize existing networks for the sharing and dissemination of information collected from the inventory, with local, regional, and State agencies with interest in HERR by September 30, 1981; and to promote the availability of the inventory through the HERR Program Newsletter. To develop and maintain working relationships with local, regional, State, and national organizations and agencies involved with or interested in risk reduction activities in 1980-1981, the State plans: to establish an Advisory Committee to the State-level HERR Program by February 1981, and to seek representation from the Department of Education, Office of Medical Affairs, Health Education Committee of Michigan Health Officers' Association, locally funded projects, Chronic Disease Control, Office of Substance Abuse Services, Office of Vital and Health Statistics, and the Great Lakes Chapter of SOPHE; to communicate HERR goals, objectives, and activities to local, regional, State, and national agencies which are involved with or interested in program functions by April 1981; to organize and conduct workshops for locally funded project managers, health educators, and representatives from schools, substance abuse, existing health education resource centers, and HSA's by April 1981; and to involve Michigan Department of Public Health Education in program activities. To establish methods to determine the prevalence of risk factors in communities and selected target populations by June 1981, the State plans: to involve HERR Advisory Committee in the determination of recommended methods of risk factor identification by April 1981; to provide technical assistance through training and consultation to local and regional agencies needing assistance to determine the prevalence of risk factors in 1980-1981; to share collected risk factor prevalence data with local, regional, and State agencies involved in risk reduction activities in 1980-1981; and to select at least three communities to gain commitment to take an organized approach to risk reduction by May 1981. To identify existing sources of data relating to chronic disease morbidity and mortality and the prevalence of risk factors to assist in the planning of improved surveillance, the State plans: to determine how data through State agencies will be accessed and reviewed to determine which items are pertinent to risk reduction programs and which items might be added to improve surveillance; to determine how data through lo-

cal private and public agencies will be identified, accessed, and reviewed; and to identify how the HERR Program will interact with other State agencies that share responsibility to improve surveillance. The FY 1981 objectives are to stimulate and assist communities to take an organized approach to risk reduction in 1980-1981; to inform communities of the characteristics of an organized approach to risk reduction (agencies within communities taking such an approach will receive priority funding for intervention proposals in 1980-1981); to visit HSA and interested communities, using workshops as a vehicle; to transmit information through the HERR Program newsletter; to identify and document which communities are undertaking an organized approach to risk reduction throughout 1980-1981; and to provide technical assistance and consultation to communities to establish, maintain, and improve an organized approach to risk reduction in 1980-1981. Activities include providing information on survey methodology, referring agencies to resources within the community to assist with data processing, using the inventory to identify and refer agencies taking complementary efforts, and providing interested agencies with intervention methodology through a bibliography developed from research of the literature.

81P-0556
Alcohol and Smoking Prevention-Intervention Program.
Marquette-Alger Intermediate School District and Dickinson-Iron Intermediate School District, MI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Alcohol and Smoking Prevention-Intervention Program is designed to (1) increase correct perceptions and knowledge about alcohol and tobacco use among the target group (students in grades 7-8 from two middle schools, with two other middle schools serving as controls); (2) decrease the occurrence of smoking and alcohol misuse by providing the target group with the necessary decision-making and social skills; (3) increase teachers' knowledge and skills in regard to smoking and alcohol prevention and intervention strategies; and (4) collect and maintain base-line data and utilize pre- and posttest evaluations to determine the current situation, reassess health risk factors, and evaluate and update the program approach. To accomplish these goals, (1) packets describing the potential programs will be sent to school principals to assess their interest in participation, and from their responses, target group schools will be chosen; (2) an advisory council will work with program staff and act as impartial observer and advisor; (3) research will be conducted to find model programs and a program will be designed; (4) activities and materials will be developed for program components, which include "Self-Concept and Media," "Information and Alternatives--Smoking," "Information and Alternatives--Alcohol Misuse," "Decision Making and Values Clarification," "Pressure-Resistance Skills and Assertiveness Training," "Your Future--To Smoke or Not to Smoke," and "Your Future--To Drink or Not to Drink"; (5) an alcohol and smoking prevention and intervention teacher manual will be developed; (6) teacher inservice training will be conducted; and (7) a final manual review, program evaluation, and a final report will be prepared. Process and outcome data for evaluation will be collected and analyzed. Process measures such as self-reports by participants and trainers, personal interviews, and participant reaction summaries will be collected following major activities in the three stages of the program, which are planning-design, implementation-followup, and evaluation. Pre- and posttests will be distributed to the control and experimental groups.

81P-0557
Arenac County Comprehensive School-Based Smoking and Alcohol Abuse Risk Reduction Program.
Sterling Area Health Project, Community Health and Wellness Center, MI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Arenac County Program is designed to (1) continue an organized countywide (school-based) approach to adolescent smoking and alcohol risk reduction, through the development of a volunteer Arenac County Coalition to Prevent Youth Smoking and Alcohol Abuse; (2) implement risk reduction strategies based on information, education, alternatives, and intervention; (3) significantly reduce the rate of youth smoking and alcohol abuse and the amount of unnecessary deaths and disability caused by these risks; (4) develop a smoking and alcohol abuse risk reduction service that will continue after Federal funding ends; (5) provide a replicable model for rural school-based delivery of services characterized by interagency cooperation and efficient organization of service delivery; (6) maintain or increase the percentage of youth and adolescents who have never smoked, and reduce the percentage who are experimental or occasional smokers by a minimum of 10 percent at the end of the first year; (7) reduce the median number of cigarettes and the tar and nicotine levels of those cigarettes being smoked by 10 percent; (8) increase the quit rate by 10 percent; (9) reduce youth alcohol consumption by 10 percent; (10) reduce the frequency of heavy drinking by 10 percent;

and (11) reduce the number of youths who define themselves as problem drinkers by 10 percent. To accomplish these goals, the program will conduct (1) an annual risk factor survey and needs assessment; (2) programs implemented by the 18-member Arenac County coalition; (3) needs assessments of the target group (about 3,500 elementary, junior high, and high school youth, and parents); (4) a training program for each of 3 Student Committees Against Smoking and Alcohol Abuse; (5) smoking and alcohol media campaigns; (6) peer and cross-age education programs (3-5 hours in length) for 90 percent of early and upper elementary schoolchildren; (7) parent workshops (4-6 hours in length) for 20 percent of all parents; (8) a smoking and alcohol abuse prevention curriculum for 85 percent of the target group; (9) a Peer Substance Abuse Counseling System in 1 high school for 10 percent of the identified high-risk population; and (10) a smoking withdrawal workshop series conducted by student committee members for 10 percent of identified smokers. Process evaluation will be conducted for (1) staff survey training, coalition board training, task force work group training, and teacher and advisor training, using standardized questionnaires and brainstorming followed by postdiscussion periods, and (2) media campaigns, peer or cross-age education programs, parent workshops, teacher-conducted curricula, and peer counseling and smoking withdrawal workshops, using pilot testing with target groups and postservice questionnaires. Outcome evaluation will measure the extent of risk reduction in the target groups, to be determined by a standardized random phone survey. Monthly evaluation reports will be submitted to the Michigan Department of Public Health.

81P-0558
Health Education Risk Reduction Intervention Activity Program.
Health Education Division, Detroit Health Department, Detroit, MI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education Risk Reduction Intervention Activity Program is designed to (1) reduce within 1 year the current smoking incidence of 32 percent by 10 percent among all female adolescents and young adults, 12-24 years old, enrolled in the family planning and gynecological services of the Detroit Health Department; (2) reduce the current smoking incidence of 31 percent by 15 percent among pregnant adolescents and young adults in this group within the third trimester of pregnancy; (3) reduce within 1 year the current drinking incidence of 27 percent by 5 percent among all female adolescents and young adults in this group; (4) reduce the current percentage of 13 percent among pregnant adolescents and young adults who drink by 10 percent within the third trimester of pregnancy; (5) reduce within 1 year the current percentage of 48 percent of this group who smoke and take oral contraceptives by 10 percent; and (6) sustain throughout the year the current nonsmoking and nondrinking status among 100 percent of the nonsmoking and nondrinking adolescents and young adults in this group. The maintenance module is for pregnant drinkers and pregnant ex-smokers; the coping module is for nonpregnant drinkers and smokers; the prevention module is for nonsmokers; the high risk module is for pregnant smokers, smokers who take oral contraceptives, and pregnant ex-smokers; and the prevention module is for nondrinkers. In all modules, participants will receive an activity book and will contract with the health educator to make behavior changes. Health educators in all modules will conduct group discussions; make presentations to groups; introduce groups to values clarification; and help participants implement stress reduction activities. The risk status of participants will be determined by using the "Health Education Risk Reduction Assessment" as a measure. For evaluation, program data will be analyzed quarterly and reported. Data will consist of pre- and posttests, self-monitoring forms, and health education assessment questionnaires. The evaluation process will not only focus on the extent to which objectives are attained but will also identify and make recommendations on the strengths and weaknesses of the program operation so that the former can be maximized and the latter modified for future program funding.

81P-0559
Health Education-Risk Reduction Program: Local Intervention Project.
Chippewa County Health Department and Luce-Mackinac-Alger-Schoolcraft District Health Department, MI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program is designed to (1) provide the vulnerable high-risk groups of children, young adults, pregnant women, and minorities cognitive and affective information to make informed decisions about smoking and alcohol use; (2) develop school and community support for the implementation of comprehensive school health education programs; and (3) expand the cooperative efforts of official and volunteer organizations in increasing citizen awareness of the harmful effects of smoking and alcohol use. A health educator will be hired to coordinate activities in participating agen-

cies; develop inservice education for selected health department employees; determine the prevalence of risk factors for Alger, Chippewa, Luce, Mackinac, and Schoolcraft Counties; and evaluate health education-risk reduction projects. The program has five components: (1) Alger and Schoolcraft County schools will implement the School Health Curriculum Project (SHCP); (2) Luce, Chippewa, and Mackinac counties will implement the Primary Grades Health Curriculum Project (PGHCP) for grades K-3 and the SHCP for grades 2-7 in coordination with other classes; (3) Peer Plus, High on Myself, Group Dynamite, the Stress Connection, the Self-Esteem Notebook, and the Health and Safety Projects will be made available through outreach by 4-H youth agents; (4) the Bay Mills Indian Community will offer Head Start for 3- to 5-year-olds; group sessions for 6- to 9-year-olds on anatomy and the effects of tobacco and alcohol; and discussions of general health practices, identification of specific stresses at work, individual and peer group examinations, and referral to Whitefish Bay Medical Center for health problems, as appropriate, for 10- to 21-year-olds; and (5) the Whitefish Bay Medical Center Component will consist of an intensive program of supportive counseling and teaching, structured in six 30-minute sessions, to increase awareness of health risk factors. The program will be evaluated by the satisfaction of participants, goal attainment status, and physical changes. For evaluation, the program will utilize the Centers for Disease Control's common data items. Each component will conduct pre- and posttests for the target group. The financial status of the project will be evaluated monthly.

81P-0560
Michigan State University Health Education Technical Assistance Program: Smoking and Alcohol Community Intervention Program.
Ingham County Health Department, and Mid-Michigan District Health Department-Clinton Branch, MI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Community Intervention Program is designed to (1) establish criteria for identifying high risk adolescent clients of the Clinton and Ingham County health clinics, (2) develop and implement a mechanism through which individuals assessed to be at high risk are given an opportunity for informed decision making, (3) develop and implement a smoking and alcohol intervention and deterrence program, and (4) develop a framework for utilizing trained volunteers in community programs and disseminate educational information. To accomplish these goals, the program will conduct (1) risk identification through administration of health hazard appraisals; (2) educational needs assessment; and (3) intervention modalities that consist of self-testing and self-help, one-to-one and group counseling, contracting, and referral. Evaluation will be conducted through computerized health hazard appraisal forms, statistical records and statistical breakdowns, comparison of pre- and posttests, and random telephone sampling.

MINNESOTA

81P-0561
Health Education-Risk Reduction (HERR) Grant Project, Minnesota.
Mills, D.
Minnesota Department of Health, Health Education Section, 717 Delaware Street, S.E., Minneapolis, MN 55440
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Minnesota was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. To maintain an inventory of existing HERR services, the HERR staff will produce, distribute, evaluate, and update the Minnesota Risk Reduction Program Resources Directory. By December 31, 1980, the HERR staff will analyze and organize responses from the initial inventory survey into appropriate geographical, risk factor, and service categories. By March 31, 1981, the State will distribute this directory to all agencies inventoried as well as other State, regional, and local organizations. By June 30, 1981, the State will develop and pretest a mechanism to evaluate effectiveness and use of this directory and a method for updating it. By September 30, 1981, the HERR Program will produce and distribute three supplements to the basic directory including human and knowledge resources, financial resources, and persons providing or employees desiring to participate in HERR programs. The HERR Program will establish a statewide committee on risk reduction composed of representatives from DHS, funded intervention activities, and other interested parties both inside and out-

side the department. By December 31, 1980, the HERR staff will identify and summarize the goals and objectives of the major agencies and organizations involved with risk reduction activities in Minnesota; all agencies and organizations will receive reports of risk reduction activities occurring throughout the State. To establish methods to determine the prevalence of risk factors, the State plans a data gathering and retrieval system to produce statewide- and HSA district-level information on prevalence of risk factors and other health data needed to plan, implement, and evaluate HERR programs. By December 1, 1980, the Physician Oriented Disease Surveillance (PODS) System will begin collecting information on the prevalence of hypertension, obesity, smoking, and diabetes among patients seen by a statewide random sample of physicians. By February 1, 1981, a health risk appraisal form will be developed for use in physicians' offices in conjunction with the PODS System. Also during FY 1981 a pamphlet will be developed for communities, agencies, and industries illustrating the importance of questions to ask prospective vendors of risk appraisal programs. By July 31, 1981, the Minnesota Department of Health will develop, pilot, and have operational a chronic disease surveillance system for the State of Minnesota. By January 1981 monthly reports on morbidity from the most prevalent diseases will be distributed to at least 7,000 health agencies and professionals. Models for using statewide, regional, and local statistics will be developed and distributed by September 30, 1981. By September 30, 1981, the State will respond to requests for assistance in two areas of community assessment: base-line prevalence of risk factors and target-group definition. It will prepare a report on barriers to behavioral change in each of the risk factor areas. The legislative, economic, and cultural obstacles to change will be analyzed and solutions suggested. The HERR Program will prepare legislative incentives and offer testimony in support of bills intended to reduce the barriers. By June 30, 1981, the HERR Program will respond to requests for technical assistance in evaluating local programs and prepare uniform tools for use by local programs in evaluating their own programs.

81P-0562
Burnsville-Farmington Teenage Smoking and Alcohol Abuse Prevention Program.
Youth Development Program (YDP), Community Action Council, Burnsville, MN
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Burnsville-Farmington Teenage Smoking and Alcohol Abuse Prevention Program is designed to (1) develop a curriculum; (2) organize teen health boards to decide how to determine on an ongoing basis the prevalence of smoking and alcohol abuse in the community; (3) develop an overall community strategy for preventing smoking and alcohol abuse; and (4) train teachers, teen health board members, and peer educators to design, implement, and assess a program aimed at alcohol abuse and smoking. Organizational health boards, composed of youth, parents, and educators, will determine periodically the prevalence of teen smoking and drinking in each community and develop a prevention strategy based on prevalence data and other information. Local teachers, consultants, and the youth development staff will develop a curriculum focusing on personal decision making and other approaches to personal development and enhancement of self-concept. Four teams of 15-20 youths will be trained in the use of the curriculum. The target group will consist of 9,802 students in the suburb of Burnsville and 2,250 in the rural community of Farmington. Process, participant outcome, youth aggregate outcome, and curriculum evaluation will be conducted. Activities will be documented; data corresponding to objectives and standards of performance will be analyzed; prevalence data gathered from target population and control groups will be collected; pre- and postprogram instruments will be administered; a quasi-experimental technique, involving a self-report instrument administered before and after the program, will be used to evaluate youth aggregate outcomes; and contracted teachers and consultants will evaluate the curriculum, possibly through participant reactions and changes in knowledge, attitudes, or skills.

81P-0563
Health Education-Risk Reduction Project.
Independent School District No. 793, Staples Public Schools, Staples, MN
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Project is designed to (1) emphasize prevention to young students; (2) inform students of the risks involved in drug, alcohol, and cigarette use; (3) teach students to avoid peer pressure and develop a more positive self-concept; and (4) implement programs that will affect all students in the district. Teachers will be trained by personnel of Operation Aware in Duluth and will design a program modeled after Operation Aware. These teachers will also attend a 5-day workshop to reach consensus on methods of reaching students at each grade level. Data will be analyzed and additional teachers in the district will be surveyed to clarify the needs of the program. A model program will be constructed with

specific goals and objectives for grades 4-6, and test materials will be developed for each grade level. The activities will include rap sessions with students, field trips, use of audiovisual materials, role playing, and meetings with nonsmoking and nondrinking high school students. All students in grades 4-6 will receive instruction in the developed program for 12 weeks twice a week for 45 minutes, to be conducted by trained teachers or the project director. There will be five sessions at each grade level. Training conducted by the State Department of Education to enable teachers to implement the Seattle Project, or the Primary Grades Health Curriculum Project, and the Berkeley Project, or the School Health Curriculum Project, will continue. Ten teachers will work for 1 week, 4 hours a day, ensuring that program goals are congruent. Communication with the general public will be carried out through newspapers and meetings. The Staples School Board will be reported to every other month, and the Minnesota Department of Health will be reported to when appropriate. The target group will consist of all school district students. The first and most of the second year of the project will concentrate on grades K-6; years 3-4 will place emphasis on junior and senior high school. An outside evaluator will help design instruments to evaluate each activity. Students will be followed through high school and after graduation. All project activities will be documented, and process logs will specify dates, activities, participants, and effectiveness of the activities.

81P-0564
Minnesota Physician-Oriented Disease Surveillance (PODS) System.
Minnesota Department of Health, 717 Delaware Street, S.E., Minneapolis, MN 55440
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Minnesota Physician-Oriented Disease Surveillance (PODS) System will be developed, piloted, and operated by the Minnesota Department of Health. Monthly reports on morbidity due to the most prevalent diseases will be distributed to at least 7,000 health agencies and professionals. Models for the use of statewide, regional, and local statistics will be developed and distributed. This will increase the State's capacity to obtain morbidity information on chronic diseases. Specifically, the system will collect data from a random sample of physicians in the State for a period of a day or a week. If different physicians are recruited each day or week, the reporting load will be distributed so that it does not fall heavily on any one source. Automated data processing will be used to develop data files on new diseases and unprecedented occurrences of any known disease. Development of appropriately clear and understandable outputs will proceed in step with computer development during the pilot project. Evaluation will consist of comparing the results of the PODS system with those of the National Ambulatory Medical Care Survey and the National Health Interview Survey. Information on specific diseases from special sources will also be used to check the accuracy of the system. This is particularly true of Olmsted County where the unique studies of the Mayo Clinic Epidemiology group provide complete and detailed morbidity figures for selected diseases for the entire county.

81P-0565
Teen-Family-Community Model.
School of Public Health, University of Minnesota, MN
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Teen-Family-Community Model is designed to (1) sensitize families to the influence of family environment (communications, values, and substance use) on younger family members; (2) help teenagers understand and deal with their emerging sense of values and concepts and with decision making; and (3) promote an improved level of mental and physical health in junior and senior high school students and in families. To accomplish these goals, the program will utilize (1) base-line assessment by survey to determine the community's major lifestyle health risks; (2) peer leaders within each class and family leaders within the community who will work with community health educators to improve value formation and communication among peers and family members, and (3) family sessions in the community with up to four families working together on the two areas of lifestyle health risks and communication in families as it relates to health. The target group will consist of students in county junior high and high schools, their families, and other interested persons in the county. Evaluation will be conducted through pre- and postprogram controlled surveys of the lifestyle health risks, particularly alcohol and drug use, and communication and values-clarification capabilities of peer groups and families.

MISSISSIPPI

81P-0566
Health Education-Risk Reduction (HERR) Grant Project, Mississippi.
Garrison, B. G.
Mississippi State Board of Health, Bureau of Family Health Services, P. O. Box 1700, Jackson, MS 39205
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Mississippi was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. An inventory of health education resources is underway and will be available to all health-related groups in the State, especially those involved in intervention projects. The State plans to organize a group of official and voluntary organizations to present a statewide information campaign on lifestyle; establish a speaker's bureau, using representatives of Blue Cross-Blue Shield, the Health Systems Agency, and the Mississippi Interagency Council on Smoking and Health; and conduct an antismoking campaign in cooperation with DOC (Docs Oughta Care). Approximately 8,500 junior high school students in 57 control and 57 target schools have been surveyed on their health behaviors and attitudes. After a health education campaign, the students will be surveyed again to measure changes in health behaviors and attitudes. The employees of health departments within the State will be surveyed before and after participation in an employee health education program to measure changes in their health behaviors and attitudes. A research consultant for the University of Mississippi Medical Center will continue to gather morbidity and mortality data related to certain risk factors by using data from 18 hospitals, each of which has at least 150 beds. In 1981 data on an additional risk factor--alcohol abuse--will also be collected. Schools, State health departments, and communities will be the focus of these projects. The State plans to conduct a health education campaign in target schools. Professionals from various health organizations will be available to assist teachers in health instruction. Local health departments, parents, and community groups will also be involved in the projects. Local school nurses will do simple health checks on all children in the target classes. Teachers will be encouraged to use films on health that the project will provide. Puppet contests will be conducted in the target schools to involve students in creating skits on lifestyle and risk factors. In May 1981 the project will be evaluated for each school; students will be asked about their areas of interest related to health. The State also plans to instruct staff members of all health departments within the State about nutrition, smoking, and exercise. Both the school and health department projects will be publicized through radio and television announcements. Community intervention projects will be assisted in determining what problems are common in their community, identifying and coordinating resources, developing a workplan, and evaluating progress.

81P-0567
Health Education-Risk Reduction Project: Tobacco and Alcohol Abuse.
Mississippi Band of Choctaw Indians, Philadelphia, MS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Project is designed to (1) raise the knowledge level among students about the health problems associated with alcohol and tobacco use; (2) reduce the number of smokers in the target population (Choctaw children and adolescents on the Choctaw reservation and adjoining counties, approximately 1,550 people, and their parents and families) by 4 percent (20 percent long term); (3) reduce the number of heavy drinkers by 5 percent (25 percent long term); (4) reduce the number of deaths due to alcohol-related accidents by 2 percent (10 percent long term); and (5) reduce the number of visits to the hospital for alcohol-related accidents and violence by 5 percent (25 percent long term). The program will be conducted through (1) training of existing staff (health professionals, school teachers, community health workers, and mental health and alcoholism counselors); (2) educational activities in grades 1-12; (3) development of alternative activities for children and adolescents through the use of volunteers and personnel in existing tribal programs; (4) communitywide education geared toward students' parents and families; (5) use of volunteers, especially students, as peer counselors and leaders in changing attitudes about smoking and drinking; and (6) integration of smoking and alcohol education into a school risk reduction program. Process evaluation will be conducted quarterly in three ways: hours of training for staff will be recorded and compared to estimated need; number of hours of classroom activity devoted to alcohol and tobacco education will be compiled and compared with goals; and number of contacts made in the communi-

ty will be compiled and evaluated. Product evaluation will be conducted quarterly by comparing stated objectives with hospital statistics, health statistics, and test scores. Surveys will be administered to measure attitude change. The risk reduction director will be responsible for evaluating the project, with assistance from a health educator and health planner.

81P-0568
Risk Reduction Project.
Region I Mental Health Center Substance Abuse Services, Clarksdale, MS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Risk Reduction Project is designed to (1) increase the number of adolescents exposed to educational material on alcohol and tobacco use, (2) increase the number of adolescents provided with intra- and interpersonal skills training for making informed decisions about alcohol and tobacco use, (3) increase the number of adolescents participating in established alternative programs related to alcohol and tobacco use, (4) increase interagency affiliations and communication among community resources, and (5) decrease the use of tobacco and the abuse of alcohol among adolescents. To accomplish these goals, the program will (1) provide inservice training to teachers; (2) provide training to teachers in the use of specific techniques for affective education, to be incorporated into classroom settings; (3) recruit and train students to act as peer tutors and counselors; and (4) offer various alternatives, including the possible establishment of a youth activities center in each of the four counties, and field trips to sites offering positive experiences that do not involve alcohol. The target group will consist of minority adolescents in the four-county service area of the Region I Mental Health Center. Evaluation will be conducted through pre- and posttests and through a multiple base-line assessment, to evaluate the project's overall effectiveness, using random samples and control groups at 6-month intervals.

81P-0569
Smoking and Alcohol Risk Reduction Among Adolescents.
South Central Mississippi Rural Health Association (SCMRHA), Inc., MS
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Smoking and Alcohol Risk Reduction Among Adolescents is designed to demonstrate that a health education program for adolescents, based in local community health centers and working through adolescent and adult volunteers in area churches and schools, can effectively decrease smoking and alcohol use among participating youth (adolescents in Mendenhall, New Hebron, and Jackson). To accomplish this goal, the program will (1) recruit and hire staff; (2) conduct a survey on smoking and alcohol use among adolescents; (3) hold an orientation for staff, volunteers, consultants, and community contacts; (4) obtain the cooperation of the pastors of 5-8 local churches in each of the target areas; (5) develop program objectives and evaluation plans based on surveys, community input, and technical assistance; (6) develop a training manual for use by volunteer health advisors acting as counselors; (7) select 8-16 adult volunteer health advisors from local churches; (8) select and equip 10-15 youth volunteer health advisors; (9) implement a 12-week smoking and alcohol risk reduction training session for youth and adult volunteer health advisors in the 3 target areas; (10) develop a library of health education media suitable for grassroots community education; (11) establish 14 community health councils as vehicles for adolescent smoking and alcohol risk reduction education; (12) establish 10 school health clubs to discuss health concerns related to smoking and alcohol use; and (13) allow individuals to seek individual counseling from either an adult or an adolescent counselor. For evaluation, initial and reassessment surveys will be conducted. Evaluations will consider the number and percentage of people enrolled in training who attend the sessions, the number of school health clubs and community health councils, and the number and nature of personal counseling encounters reported by trained community members.

MISSOURI

81P-0570
Health Education-Risk Reduction (HERR) Grant Project, Missouri.
Rikard, B. E.
Missouri Department of Social Services, Division of Health, P. O. Box 570, Jefferson City, MO 65102
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Missouri was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The HERR program will maintain and distribute information from a statewide inventory of risk reduction services beginning October 1, 1980. By October 31, 1980, a computer system will be implemented to allow intervention projects and other prevention agencies to share technical assistance on specific topic areas relating to HERR. During FY 1981 organizations and individuals will receive a list of HERR programs in their areas, and statewide information will also be made available to them. The inventory of HERR services will be updated to maintain current information. During FY 1981 the Missouri Bureau of Community Health Education will maintain or increase its working relationships as evidenced by completion of the following objectives: By December 1980 the Missouri Bureau of Community Health Education and the American Cancer Society will complete development of a cooperative system of training smoking cessation facilitators; by April 1, 1981, the HERR program will propose use of the Missouri Health Education and Lifestyle Promotion program to at least eight industries in the State; and by March 15, 1981, the HERR program will assist at least three unfunded communities to take an organized approach to risk reduction. During FY 1981 the Missouri Bureau of Community Health Education and Missouri Prevention Network will cooperatively publish HERR data through a supplement to the journal "Networks"; the Missouri Bureau of Community Health Education will continue to develop new working relationships with organizations and individuals as evidence of interaction with Secondary Education, the State Department of Mental Health (Division of Alcohol and Drug Abuse), and various other State and local agencies. By November 1980 the Missouri Bureau of Community Health Education plans to provide all funded intervention projects and at least three communities with materials and methods to determine prevalence of risk factors in their communities using CDC's recommended Common Data Items. By November 15, 1980, representatives from funded intervention projects will be required to attend a workshop which will address the following topics: instrument design, survey methodology, analysis of data, evaluation of results, and commitment of resources to address results. The Missouri Bureau of Community Health Education and the University of Missouri-Section of Community Health will design a method to determine the prevalence of risk factors in each community. This will include suggested methodology, evaluation of results, training of volunteers in the community, community organization, and training to address survey results. During FY 1981 the Missouri Bureau of Health Education will continue to make available to any organization on a county-by-county basis information relative to HERR programs. Available data systems will be searched and upgraded to provide up-to-date information. By March 1, 1981, a file on each of the 114 counties will be completed and will contain the most recent data on at least the following topics: percentage of smoking mothers, number of packs of cigarettes taxed locally, cancer incidence (by type of cancer), hospital discharge (by type of hospitalization), cause of death, estimates of alcohol abuse prevalence, and estimates of nutritional status. During FY 1981 the Missouri Bureau of Health Education will assist communities in organizing HERR activities. Using the computerized system, HERR program staff will contact all organizations in at least five unfunded communities to organize HERR activities including: contact of agencies, conduct of organizational meetings, determination of risk factor prevalence, coordination of intervention programs, and program evaluation. By April 30, 1981, the Missouri Bureau of Community Health Education will stimulate and receive at least 15 community proposals (new or continued) to address specific target groups, supported by specific, measurable, and reasonable objectives. By April 30, 1981, the Missouri Bureau of Community Health Education will stimulate and receive at least four proposals that address highly susceptible and minority target populations. By August 31, 1980, the HERR staff will develop a system to continually provide current status information on all funded intervention projects. By November 15, 1980, all funded intervention projects will be provided with training to carry out grant and objectives' requirements. During FY 1981 the University of Missouri-Section of Community Health Education will receive a contract from the Bureau of Community Health Education to (1) provide technical evaluation service to consist of the following activities: technical and physical assistance in planning, implementation, and evaluation of training workshops and conferences; (2) provide funded intervention projects with methodology to administer the annual risk factor prevalence survey; (3) provide computerized comparison of each intervention project to determine relative effectiveness of these programs; and (4) assist in organizing communities to carry out HERR activities.

81P-0571
Bi-State Metropolitan Risk Reduction Approach.
Metropolitan Official Health Agencies of the Kansas City Area (MOHAKCA), MO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.

1980 - Continuing.

The Bi-State Metropolitan Risk Reduction Approach is designed to (1) coordinate existing risk reduction services in the target area (Kansas City metropolitan area) and provide impetus for establishing new programs to meet the population's needs, (2) incorporate the "1990 Objectives for the Nation" into the program plans and policy statements of nine local health departments; (3) promote communication and diffusion of innovation through an organizational base to assure a logical progression of risk reduction service provision; (4) assure that a matrix of comprehensive risk reduction programs will exist to serve the area by 1985; (5) encourage and gain commitments from people in decision-making positions to emphasize the reduction of known risk factors in the populations they serve; (6) assure that all health departments providing hypertension screening services utilize a common method of assessing categories of hypertension control; and (7) gain the commitment of four health departments for the implementation of an areawide accident prevention program to begin in October 1981. To accomplish these goals, (1) representatives from local health agencies will develop guidelines to evaluate existing risk reduction standards, develop a survey to determine existing evaluation methods, and assess current methodologies; (2) local health departments will review these guidelines, and, when they have been approved, the final guidelines will be published; (3) a survey on the prevalence of risk factors will be conducted in the eight-county area, based on the Centers for Disease Control's common data items; (4) a survey of the area health departments and voluntary health agencies will be conducted to identify present risk reduction intervention projects and resources; (5) a commitment will be solicited from each area health department to assist the Public Health Service in the National Health Promotion Media Campaign; (6) a system will be developed to accumulate and maintain information on the status of various risk reduction activities; (7) technical assistance will be provided to local health departments; (8) four health departments will plan a risk reduction activity to be implemented by October 1981; (9) a strategy will be designed for support of risk reduction in the city; (10) a questionnaire will be distributed to evaluate the hypertension control programs in the area health departments, the data from which will be analyzed and published; and (11) an inpatient and a media plan for accident prevention will be developed. For evaluation, a self-reporting system will be developed for all local health departments and the area risk reduction intervention providers. For the first year, process rather than outcome objectives (in terms of reduction of risk) will be the focus. To determine the prevalence of risk factors in the area, a random digit dialing survey will be conducted during the first quarter, with a reevaluation in April 1981.

81P-0572
Community-School Health Education.
SERVE, Inc., Fulton, MO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Community-School Health Education program is designed in the first of 4 years to (1) conduct a health assessment survey of the 1,028 students in Fulton public schools, grades 7-12; (2) develop a coordinated community-school plan to identify risk factors and initiate health education programs aimed at those factors; (3) reduce the current rate of smoking among the target group by 20 percent over the project period; (4) reduce the prevalence of alcohol use and experimentation by 20 percent; (5) train 12 high school students as lay health educators and referral makers; (6) foster and encourage adult-teen interaction so that positive adult role models can be established; and (7) develop school-community cooperation in health education programs by increasing participation by parents, health providers, and community members in the planning, implementation, and utilization of health education-risk reduction activities. To accomplish these goals, (1) an assessment tool will be developed and administered to junior and senior high students; (2) a health education coordinator and community health educator will study survey results and plan activities; (3) the health educator will develop resource materials for teachers and a smoking prevention plan; (4) teachers will integrate the curriculum; (5) the health educator will form student committees to help plan and implement programs to prevent smoking and alcohol abuse; (6) support will be solicited from community resources; (7) a student peer-education steering committee will be formed, and 12 high school students will be trained as peer health consultants; (8) smoking cessation sessions will be set up for parents and teens; (9) quarterly interagency meetings will be held to share information about health education in the county; and (10) a cooperative community program on one of the health risk factors will be established. The project will be evaluated by comparing actual accomplishments with stated objectives and a timetable. Pre- and posttests will be administered.

81P-0573
Coordinated Agency Risk Reduction-Health Education: A Community Based Risk Reduction Program Concerning Tobacco and Alcohol Use Among Minority Youth.
Family Counseling Center, Inc., and Everyday People, Inc., Columbia, MO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Coordinated Agency Risk Reduction-Health Education program is designed to (1) conduct a base-line survey of risk prevalence; (2) create a healthier environment for Columbia minority 12- to 17-year-olds by focusing on reduction of alcohol and tobacco use during the first project year; (3) reduce the risk factors associated with smoking, alcohol abuse, stress, hypertension, and obesity among minority youth over a 4-year period; (4) use peer modeling and positive models of teen-adult interaction; (5) coordinate existing health services and strengthen interorganizational cooperation to improve services offered to the community; (6) initiate, by the end of a 4-year period, a system that the black community can adopt to assume risk reduction activities under its own leadership; (7) provide a vehicle for agencies, different age groups, and mixed racial groups to cooperate at a level that does not currently exist, thereby reducing barriers; and (8) provide youth with alternatives so that they may choose to adopt healthier lifestyles, and involve them in the planning and implementation of school and community programs addressing risk reduction. To accomplish these goals, the program will (1) develop and implement a risk prevalence survey; (2) establish a network that includes the school system, health service organizations, and concerned professionals; (3) encourage interracial cooperation on risk reduction projects using workshops and radio programming; (4) identify peer network leaders and recruit and train 17 youths, predominantly black, to act as peer health educators and referral makers; (5) develop cooperation between local health programs and public schools using workshops and community involvement as tools; (6) assess the prevalence of smokers in the target group and implement smoking reduction programs by providing health education teachers with information from the risk prevalence survey and by using radio spots and classroom presentations; (7) reduce alcohol use in the target group using flyers, posters, and presentations on fetal alcohol syndrome and other alcohol-related topics to classrooms and adults; and (8) encourage adult-teen relations so that positive adult role models can be established. The primary evaluation will be process oriented. Impact evaluation will be performed by giving pre- and postprogram tests to participants to determine changes in attitude.

81P-0574
Health Education-Risk Reduction for a Black Youth Community.
Miracle House Youth Center, Kansas City, MO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Health Education-Risk Reduction for a Black Youth Community is designed to (1) provide opportunities for youth to develop desirable social attitudes through twice weekly sessions on values clarification and attitude exploration; (2) help youth develop an awareness of the importance of health to the individual, through health-promoting creative activities to deter smoking and alcohol consumption; (3) provide opportunities for youth to develop self-direction abilities and intelligent and responsible decision making about alcohol and tobacco, through regularly scheduled sessions on decision-making skills; (4) provide regular fact sessions on alcohol and tobacco use, and increase the participants' awareness of their consequences; (5) help youth develop an awareness of the significant impact of peer, parent, and mass media influences on habit formation; (6) help youth develop an awareness of sources of health information; (7) provide social, cultural, and recreational activities for the participants as alternatives to alcohol and tobacco use or abuse; and (8) incorporate strategies to combat associated risk factors such as obesity, stress, and hypertension. To accomplish these goals, the program will (1) determine base-line prevalence of risk factors, determined through a dual approach survey instrument and administered to a random community sample and to two elementary schools; (2) identify representatives from the Missouri Bureau of Community Health Education, cooperating organizations, and host advisory committee meetings to implement methods and elect officers; (3) coordinate all schedules of planned activities from cooperating agencies; (4) develop and distribute appropriate brochures, posters, and calendars; (5) identify all interested target group members and implement the weekly sessions, to include information dissemination, affective education, and alternative activities; (6) expand the curriculum offered at the sessions to meet all objectives; and (7) offer intervention counseling activities, including peer and cross-age counseling. The target group will consist of 150-200 black male and female youths, 5-14 years old, from a Kansas City neighborhood. The primary model for evaluating the total program will be process evaluation, which will generate useful data to demonstrate accountability and self-improvement. Service delivery characteristics and procedures, characteristics of the target population, and staff characteristics and activities will be evaluated.

81P-0575
Health Education-Risk Reduction Program for Hannibal, Missouri.
Mark Twain Regional Advisory Commission, Hannibal, MO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program for Hannibal, Missouri, is designed to reduce alcohol consumption and smoking among 12- to 18-year-olds and smoking mothers by 5-7 percent. The program will be conducted through (1) data obtained on alcohol and smoking for Marion County, Hannibal, and the target school population; (2) intensive monthly sessions in physical education or health education classes; (3) a syllabus on smoking and alcohol consumption written through the coordinated efforts of school personnel, cooperating agencies, and staff; (4) smoking cessation clinics for the school age population and general adult population; (5) an index and schedule of suitable films and literature prepared for use by adolescents and adults; (6) a positive peer pressure program, enlisting the aid of nonsmoking or -drinking students in panel discussions about smoking and alcohol consumption, and (7) surveys and interviews conducted for reaction and evaluation. Evaluation will be conducted through (1) comparison of pre- and postprevalence surveys; (2) interviews to assess the impact of programs and clinic services; and (3) measurement of program attendance.

81P-0576
Health Education-Risk Reduction--St. Louis.
St. Louis Division of Health, MO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction--St. Louis program is designed to (1) use peer counselors in reducing the prevalence of smoking and alcohol use and abuse; (2) reduce the prevalence of adolescent cigarette smokers in the target groups (250 students, 85 percent of whom are nonwhite, in the Continued Education School for pregnant teenagers, and adolescents in the Mill Creek Health District, a disadvantaged low-income and public housing area) by 20 percent; (3) reduce the prevalence of alcohol abuse in the target groups by 12 percent; and (4) upgrade the health status of the target groups. Behavior of target group members in terms of smoking, alcohol abuse, hypertension, exercise, nutrition, accident prevention, and stress will be assessed. Selected peer trainees will participate in a structured curriculum that will prepare them to teach the target groups. The program will offer peer counseling, with teenage peer leaders providing discussion groups, individual counseling, referral information, support, and health information; smoking cessation clinics and Alateen programs; hypertension screening with appropriate referral and followup; and health status assessment to determine reduction in the prevalence of risk factors and project effectiveness. Base-line and annual assessment of risk factor prevalence will be conducted.

81P-0577
Independence, Missouri-Health Education Project's (IM-HEP) Adolescent Smoking-Alcohol Risk Reduction Program.
American Nurses' Foundation, Inc., Independence, Missouri-Health Education Project, Independence, MO
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Adolescent Smoking-Alcohol Risk Reduction Program is designed to (1) demonstrate that a school- and community-based health promotion-risk reduction program can effect positive behavioral changes in participants; and (2) have 15 percent of health education workshop participants attend a smoking cessation program, 50 percent of whom will quit smoking for 6 months, and 25 percent for 12 months. To accomplish these goals, students in grades 7-10 will participate in specific risk reduction activities, including testing, screening, classroom curriculum and activities, referral, and special projects. Base-line risk prevalence data will be collected and annually reassessed, using the Centers for Disease Control's common data items instrument. A smoking cessation program, the Know Your Body fitness program, and the Life Skills Training program will be conducted for children. The target group will consist of 1,200 students in grade 4 and in grades 7-10 from 4 schools. Measurement tools currently in use to determine risk prevalence will be evaluated in relationship to the common data items and modified to incorporate questions on smoking and alcohol use. Community risk factor prevalence will be reassessed annually. The project will be evaluated on the basis of meeting the time objectives for specific components, and on the basis of student participation, teacher response, parental involvement, and community support.

MONTANA

81P-0578
Health Education-Risk Reduction (HERR) Grant Project, Montana.
Skinner, M. D.
Montana Department of Health and Environmental Sciences, Preventive Health Services Bureau, Cogswell Building, Helena, MT 59601
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Montana was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The inventory will be compiled by the project coordinator, a statewide task force on chronic disease prevention, and a group of State agencies working together. Local health departments, school districts, county youth development coordinators, and cooperative extension agents will also be surveyed regarding HERR activities. During 1981 the bureau will establish a task force, including representatives of State and local government, professional groups, and voluntary organizations, on preventing chronic disease. This task force, the State Coordinating Council for Health Education, will: (l) assess current resources and activities related to HERR and chronic disease prevention; (2) develop cooperative plans for diabetes and hypertension health education at the community level; and (3) help determine the State's involvement in control and education efforts. During 1981 the applicant will design and conduct surveys on health hazard behavior and attitudes. Since the routine collection of risk factor prevelance data will initially depend on collecting data through local intervention activities, the expansion of routine collection will thus depend on stimulating more intervention activities. Other estimates will be made using measurements like cigarette sales, etc. Additionally, the State will determine and reduce those risk factors prevalent among pregnant women in Montana and conduct surveys among specific target groups--pregnant women, participants in the pilot HHA program, and physicians--to determine attitudes and prevalence of risk factors. During 1981 the bureau will establish a surveillance system for smoking-related illnesses by utilizing mortality data and hospital discharge data. In 1981 the CDC Common Data Items will be incorporated into the system. The State will plan, develop, and coordinate a statewide public information program with special emphasis on cigarette smoking; increase the number of community HERR projects by consultation with and technical assistance to local communities; monitor and consult with school- and community-based projects receiving grant support; conduct an antismoking campaign directed toward pregnant women through 80 percent or more of Montana's prenatal programs; and develop a health hazard appraisal program for the public by initiating a pilot program among State employees.

NEBRASKA

81P-0579
Health Education-Risk Reduction (HERR) Grant Project, Nebraska.
Harris, F. D.
Nebraska State Health Department, Community Health Education, 30l Centennial Mall South, POB 95007, Lincoln, NE 68509
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Nebraska was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. During FY 1981 HERR staff will develop and maintain the inventory of existing HERR programs and services. By January 1981 they will assemble and have available an inventory of HERR agencies or organizations in at least l5 counties in Nebraska, and by November 1, 1980, identify agencies and organizations to be inventoried. The State will utilize health agency listings available from the three Nebraska Health Systems Agencies, the State Agency Directory, mailing lists from the State Health Department's Licensure and Standards Division, and the Community Health Education Division. Final format of the inventory survey instrument will be determined by November 1, 1980, following a review of inventory forms from HERR programs in States which developed them. By December 22, 1980, HERR staff will create a resource file according to county and specific risk factor, to be updated annually; and by February 1, 1981, potential users will be notified of the inventory's availability. By May 1, 1981, the inventory's staff will assist communities proposing to use an organized approach to risk reduction to develop local HERR inventories where none already exists, by providing a suggested format and meeting to discuss inventory techniques and uses. A copy of inventory information obtained will be included in the statewide inventory. By October 31, 1980, the HERR staff will have met at least once with an appropriate representative of the staff of each agency with which the State has a working relationship. These organizations will be asked to review HERR program activities, and the HERR staff will provide technical assistance to HERR intervention programs, assist in

community risk factor prevalence determination in HERR-funded communities, and assist in publicizing HERR program information. By March 1981 HERR staff will sponsor a series of regional conferences throughout the State to explain HERR program goals and activities, demonstrate the achievements of communities undertaking an organized approach to risk reduction, and promote the "Model Standards for Community Preventive Health Services," and the "1990 Objectives for the Nation." By April 1, 1981, HERR staff will meet personally with local health departments in at least 15 Nebraska communities to explain goals of the HERR program, describe activities and acievements, and to explain and promote the "Model Standards for Community Preventive Health Services," and the "1990 Objectives for the Nation." By December 1, 1980, HERR staff will develop and implement appropriate evaluation and monitoring techniques for community organizations involved in HERR interventions, and meet at least three times with faculty members of the University of Nebraska School of Health, Physical Education and Recreation, Department of Educational Psychology, and Department of Social Work for consultation and assistance in developing these evaluation and monitoring techniques. The State has developed a definition of working relationships as follows: By September 30, 1981, HERR staff will develop working relationships with at least 10 of the following agencies or organizations and with as many others as can be identified through these contacts. A working relationship will be evidenced by two or more of the following: determination of common objectives; cooperation in the determination of risk factor prevalence in at least one community; resource sharing in coordinated activities related to HERR programs and involved communities; participation in reassessment of the level of activities necessary to reach desired community objectives; and planning and implementation of cooperative HERR activities to assist communities in achieving these objectives. Agencies include: Nebraska Department of Education; Nebraska Division on Alcoholism and Drug Abuse Prevention; University of Nebraska-Lincoln; State Parent Teachers Association; American Cancer Society; American Lung Association; American Heart Association; University of Nebraska Medical Center; Greater Nebraska Health Systems Agency; Southeast Nebraska Health Systems Agency; Health Planning Council of the Midlands; Nebraska Medical Association; Nebraska Nursing Association; Nebraska Public Health Association; and Nebraska Pharmacy Association. By December 15, 1980, HERR staff will develop methods for risk factor prevalence determination in HERR-funded communities and target populations within the communities. By November 15, 1980, HERR staff will meet at least twice with staff members of the following agencies to discuss appropriate research and statistical methods to provide reliable information on risk factor prevalence: Nebraska Department of Health (Health Data and Statistical Research Division, and the Division of Health Systems Planning); University of Nebraska-Lincoln (Schools of Health, Physical Education and Recreation, Department of Educational Psychology, and Department of Social Work), and the Bureau of Sociological Research. By November 30, 1980, HERR staff will identify and meet with local agencies in HERR communities experienced in data collection or risk factor identification to involve them in data collection activities, and by January 1, 1981, provide training in survey techniques for survey workers in all HERR-funded communities. HERR staff will inform community survey staff that CDC-recommended Common Data Items and suggested survey format will be used to determine risk factor prevalence. By April 1, 1981, HERR staff will analyze and

81P-0580
Neighborhood Family Service Center Health Education-Risk Reduction Project.
Health Task Force for the Underserved, Neighborhood Family Service Center, Scottsbluff, NB
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Neighborhood Family Service Center Health Education-Risk Reduction Project is designed to (1) increase minority and low-income people's access to medical treatment; (2) broaden health education programs to include underserved individuals; (3) minimize cultural barriers to the health care system; (4) develop a program to address alcohol and drug abuse among community youth; (5) initiate health education programs designed to modify existing poor health habits and behaviors; (6) increase participation in health education programs by providing transportation or opening neighborhood sites for classes and clinics; and (7) establish an organizational structure to coordinate health education-risk reduction services. To accomplish these goals, (1) health screenings and educational consultations will be provided to 600 residents of the Guadalupe area (out of a total population of 1,847, many of whom have low incomes and are minority group members); (2) clients will be referred to health care facilities as appropriate; (3) specific group educational programs on at least 4 health conditions will be developed; (4) instruction will be provided to student nurses in cultural awareness, physical assessment, and referral practices, and students of social work and human services will be educated for work in a multicultural community; (5) a risk factor prevalence study will be conducted; and (6) the Native American Youth Alcohol and Smoking Project and the Bilingual Youth Education Program will be offered.

Performance and process will be evaluated. Behavior changes and the extent of medical community cooperation with the health task force governing body will be measured. Surveys will be utilized to measure client satisfaction.

81P-0581
Risk Reduction Program for Employees.
Nebraska Department of Health, 301 Centennial Mall South, P.O. Box 95007, Lincoln, NE 68509
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Risk Reduction Program for Employees will demonstrate the nature and potential benefits of employee risk reduction programs. Services, evaluation, and training are intended to form a permanent program which has the potential for becoming self-sustaining. Operationally, the Nebraska Department of Health and the University of Nebraska-Lincoln will collaborate to educate individuals about health-related behaviors and encourage them to take more responsibility for personal health care. Selected physiological and behavioral traits of participants will be evaluated to determine an individual's susceptibility to health problems associated with certain risk factors. Employees of the Nebraska Department of Health and the University of Lincoln-Nebraska will form the target group. Evaluation, which will use data on each participant's physiological and behavioral traits, will determine the current status of these traits; identify changes in behavior that may improve health; and identify community resources that may be helpful in making such changes. The program aims to help individuals recognize and modify behaviors related to increased risk of various health problems. It also aims to stimulate increased participation in physical fitness activities.

NEVADA

81P-0582
Health Education-Risk Reduction (HERR) Grant Project, Nevada.
Cohen, P.
Nevada Department of Human Resources, State Health Division, 505 East King Street, Carson City, NV 89710
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Nevada was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The State will contract with the Health Services Coordinator to update and maintain the inventory of existing HERR activities. A directory will be compiled from a survey questionnaire and from phone interviews and published. Working liaisons will be established with county health districts, voluntary health agencies, professional organizations, and education groups. Workshops will be held to introduce the concept of HERR to agencies and organizations associated with county programs. CDC Common Data Items will be used to collect prevalence data. For prevalence of risk factors in selected communities, a meeting will be held to plan methods. Agencies will be asked to provide volunteers to aid in phone surveys and home surveys. Agencies will be asked to provide previously collected data. In cooperation with the University of Nevada a statewide prevalence survey will be developed and tested, and an indepth prevalence survey will be conducted in Clark and Washoe counties. Local and State agencies will be contacted for permission to review pertinent data. A contract will be made with the University of Nevada to provide an ongoing method of monitoring changes in illness and risk factor prevalence and to develop methods to improve surveillance. Workshops will be held through county health departments for the purpose of organizing and promoting the use of an organized approach to risk reduction assistance, and consultation will be supplied to organizations on the "organized approach."

81P-0583
Community Adolescent Smoking and Alcohol Program.
Clark County Health District, NV
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Community Adolescent Smoking and Alcohol Program is designed to reduce by 1 percent by September 30, 1985, (1) the prevalence of smoking in the Clark County community, from the level indicated by the Clark County random digit dialing survey of health risks; and (2) automobile-related deaths and alcohol-related injuries. To accomplish these goals, a community task force will be created consisting of local voluntary and State health

agencies, school personnel, and parents and students. The task force will have smoking and alcohol education components. Their functions will be to (1) review the results of a countywide survey undertaken to determine the prevalence of risks associated with smoking and alcohol; (2) review and evaluate national programs and curricula on smoking and alcohol; (3) develop work units on smoking and alcohol education to be implemented in the target schools; (4) plan and participate in teacher inservice training; (5) plan and participate in program implementation; (6) help develop public information and media; (7) review school policies regarding smoking in school; and (8) review areas for future legislative proposals aimed at determining cigarette and alcohol consumption. The target group will consist of (1) students, parents, and teachers from each of four schools, and (2) all county residents for a public information and media campaign on smoking and alcohol use. For evaluation, (1) teachers who receive inservice training on smoking and alcohol education will be pre- and posttested to measure knowledge, attitude, and behavior changes; (2) informal small group discussions at the conclusion will allow for additional evaluation; (3) students will be pre- and posttested; (4) the Smoking and Alcohol Task Force will annually review evaluations from the teachers and principals; (6) students, parents, and teachers who enroll and complete the smoking cessation clinic will be contacted 6 months after the program for followup; and (7) a random digit dialing survey of 400 Clark County residents will be done to determine the program's impact.

81P-0584
Health Education-Risk Reduction Community Health Intervention Project.
Clark County Health District, Health Education, Las Vegas, NV
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Community Health Intervention Project is designed to (1) provide at least 2 percent of Clark County residents with individualized health education on reducing personal health risks, emphasizing the health hazard appraisal (HHA); (2) provide 66 group counseling sessions for interpretation of HHA results; (3) provide a stress management program to 50 percent of local employees identified as being at risk due to stress; (4) provide hypertension screening, educational counseling, and referral to 50 percent of local employees identified as being at risk due to hypertension; (5) provide the option of a cholesterol-level reduction and nutrition program to local employee groups participating in the program; (6) provide additional health education presentations pertaining to exercise, smoking, and alcohol; (7) provide the Centers for Disease Control (CDC) and Nevada with an evaluation of the project; and (8) ensure that provision has been made in Clark County for the continued use of HHA and associated counseling and referral mechanisms. To accomplish these goals, the program will (1) review current or previous health education-risk reduction service resources within Clark County; (2) inventory existing services; (3) determine the prevalence of various health risk factors, using the CDC's common data items; (4) hold workshops to inform 20 local organizations about HHA; and (5) encourage participants to adopt HHA into their own organization's service. The target group will consist of the 350,000 residents of Las Vegas, North Las Vegas, Boulder City, Henderson, and Clark County. For evaluation, a random sample of participants will be surveyed by telephone to determine whether and to what extent HHA has influenced them. The stress management program will be evaluated through in-house staff assessments of the stress management consultant. The nutrition program will be evaluated through end-of-program written surveys completed by the participants.

81P-0585
Reducing Risk Factors of Obesity.
Reno-Sparks Tribal Council, NV
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Reducing Risk Factors of Obesity is designed to (1) increase the knowledge and awareness of the target population (the 2,100 native Americans living in Reno) about the hazards of obesity; (2) provide vulnerable groups with the opportunity to make informed decisions about health; (3) reduce the prevalence of risk factors associated with obesity by September 1981; (4) develop, implement, and evaluate school programs designed to deter children from patterns of obesity; and (5) increase the community's capacity to undertake risk reduction activities called for in Public Law 93-641. The project's recreation staff will design programs with a health-related orientation to encourage physical development as a conscious effort and to develop a community standard of physical fitness. The tribal council will introduce a series of snacks for children as an alternative to junk food, develop a food buying club, offer cooking classes, encourage gardening, and work with other native American tribes to form a commodity distribution network. Over a 5-year period, changes in the target population's behavior in regard to diet and nutrition will be observed through designing and implementing a data collection system to generate detailed patient re-

cords, a survey of community attitudes on certain types of health behavior and knowledge, and a reporting system measuring citizen participation.

81P-0586
Washoe County Smoking and Alcohol Risk Reduction Program.
Washoe County District Health Department, NV
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Washoe County Smoking and Alcohol Risk Reduction Program is designed to (1) develop an effective educational unit in Washoe County using an organized approach to risk reduction; (2) reduce by 20 percent the prevalence of smoking and alcohol use among 14- to 17-year-olds by August 30, 1985; (3) decrease by at least 2.5 percent the number of adolescents who smoke by September 30, 1983, and continue this decrease each year of the project; (4) increase ninth graders' knowledge of the effects of alcohol and smoking by 20 percent by June 30, 1982, and in each subsequent year of the project; and (5) increase 14- to 17-year-olds' awareness of the effects of smoking and alcohol each year. The project expects to reach 200-250 members of this age group yearly. Alcohol consumption and smoking deterrence and cessation programs will be established for ninth graders. Also, smoking and alcohol intervention programs will be conducted for 14- to 17-year-olds in community-based programs. An evaluation plan will be designed by October 1982. Before and after the programs are conducted, questionnaires will be administered to measure teacher and student gains. A monitoring system will be set up with school nurses, local hospitals, and police stations to see if the rate of alcohol-related accidents and crimes declines during the project. The prevalence of risk factors in the target group will be documented by December 30, 1981, using the Centers for Disease Control's common data items. The prevalence of risk factors in adolescents and children outside the target group will be determined in the project years 1982-83, 1983-84, and 1985-86. These surveys will also show whether the program has deterred alcohol use and smoking. The prevalence of risk factors in adolescents and children will be documented to determine if supplemental programs are needed in the lower grades.

NEW HAMPSHIRE

81P-0587
Health Education-Risk Reduction (HERR) Grant Project, New Hampshire.
Jensen, E. J.
New Hampshire Division of Public Health Services, Chronic Disease Control, Health and Welfare Building, Hazen Drive, Concord, NH 03301
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in New Hampshire was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By January 1, 1984, the HERR Program will have ready for publication a directory of risk reduction activities in New Hampshire. This directory will contain no less than 65 percent of all such activities in operation on January 1, 1983, or in operation before the end of that budget period. To accomplish this objective, by November 1980, the HERR Program will develop and present to the New Hampshire Consortium a flyer explaining the risk reduction program and outlining the program's goals and objectives. A form, requesting information about risk reduction activities with which the agency is involved and including risk factor categories involved, target groups, and nature of activities (methodology), will accompany this flyer. By December 1, 1980, the HERR Program will establish a list of hospitals, nursing homes, human service agencies, rehabilitation centers, and regional offices of insurance providers. By January 1, 1981, the HERR Program will provide this list and 150 flyers and information forms to the community agencies so that the Community Coordinating Agencies (CCA) will be able to initiate the establishment of inventories of activities within their geographical areas. The community agency will report the results of these mailings, by May 10, 1981, to the State Coordinator so the State office can maintain a statewide inventory of risk reduction activities. The State will try to maintain a catalog of intervention programs in order to recommend startup projects as identified in the community. By May 1, 1981, the HERR Program will have placed into operation a method for establishing and reverifying working relations with other agencies sharing an interest in risk reduction. The New

Hampshire HERR Program has already formed a Consortium of concerned individuals and agencies who share a common interest in risk reduction. The Risk Reduction Consortium meets quarterly and will advise the Coordinator on risk reduction matters. The Consortium is composed of the New Hampshire's Division of Public Health Services, Bureau of Dental Health, Family Planning, Bureau of Chronic Disease Control, and Office of Alcohol and Drug Abuse Programs; various State-level national voluntary health organizations; the Manchester and Nashua Health Departments; and the New Hampshire Blue Cross-Blue Shield. One or more of these Consortium members will receive a contract to become the Community Coordinating Agency (CCA) whose purpose is to provide communities with a designated agency to coordinate community efforts. Since the CCA contract will be awarded to another agency in the Department, this will further develop cooperative strategies with other agencies. Additionally, HERR Program State Coordinators will serve on selected councils and advisory boards to develop and maintain these working relations with agencies and organizations involved with or interested in risk reduction. The State-level program office and the CCA will solicit letters of support from community agencies as well as the State HERR Program and will respond to all requests for workshops from these agencies. Beginning in 1982, agencies will be requested to submit letters of support annually during August. The State Coordinator will contact the agencies that have taken no action since their last letter, and if the agency is interested in undertaking risk reduction activities, the State-level HERR Program will notify the appropriate community office to contact the agency. In an effort to establish and maintain working relationships with other agencies, the State will publish a newsletter to inform concerned parties of the current status of risk reduction activities. A student health education internship program will be initiated with schools within a 50-mile radius of Concord, and the interns will develop this newsletter. The State HERR Program Coordinator will also be an active member of the New Hampshire Program Affinity Group (PAG) on Promotion of Healthy Lifestyles thus giving the Coordinator the opportunity to interact with and draw upon the experience of other State agencies involved with risk reduction. The Coordinator will incorporate PAG objectives and activities into the HERR Program to fulfill the basic elements of the State-level program. By October 1, 1984, the State plans to have in operation a method of determining the prevalence of risk factors among selected target populations and will have initiated the establishment of base-line data for risk factor prevalence. To meet this objective, the State will request from the Consortium members and the HSA, any risk factor prevalence data which they may have already collected. When the State receives these data, it will set up a filing system by risk factors cross-filed by community or target population and numbers and rates of people with the selected risk factor. The State will discuss with the New Hampshire Health Statistics Bureau (BHS), the designated official State health statistics agency, the possibility of using the BHS computer to determine risk factors and the correlation between risk factors and morbidity and mortality rates. New Hampshire plans to use the Common Data Items (CDI) recommended by CDC unless the State finds the CDI to be ineffectual for use in New Hampshire. The State will sponsor a workshop on the correct administration and use of the CDI questionnaire for Consortium members and agencies with funded intervention proposals. To ensure that the State is accurately measuring the impact of the intervention proposals upon target populations, each agency will report changes in risk factors of 5 percent or more. By October 1, 1984, the State program will have established a surveillance network to monitor and measure the effect of intervention activities and their impact on selected target populations. Bureau of Vital Records and Health Statistics (BHS) has responsibility for developing a method of collecting morbidity data and has been cooperating closely with the HERR Program. Because New Hampshire is sparsely settled, polling, especially concerning personal items such as health habits, is not a trusted methodology. The CCA's and intervention activity agencies will determine how to best implement the system while BHS develops the surveillance method and network. The State plans to use mass media public information programs to inform citizens of the need to participate in surveillance activities. The State will utilize a CCA concept to provide communities with a designated agency to coordinate community efforts to stimulate an organized approach to risk reduction. A subcontract will be awarded to another State agency with existing community-level operations to assume responsibility for coordinating risk reduction efforts in the communities. The CCA's will develop common objectives among community agencies and stimulate agencies into submitting intervention proposals. By October 1, 1981, the CCA will stimulate submission to the State HERR Program of at least one intervention proposal in each community.

NEW JERSEY

81P-0588
Health Education-Risk Reduction (HERR) Grant Project, New Jersey.
Ulinsky, R. S.
New Jersey Department of Health, P. O. Box 1540, Trenton, NJ 08625
Funding Source: Center for Health Promotion and Educa-

tion (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in New Jersey was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The State HERR program will contact local health departments, private organizations, State-level programs, and schools previously inventoried in order to determine the continued existence of programs, current level of activities, and planned modifications. A statewide assessment of the risk reduction programs and activities of industry will be made. A meeting of representatives from local and State agencies will be convened to establish common objectives, identify program areas and needs, develop joint activities to reduce or solve problems, and provide guidance to community groups interested in undertaking risk reduction activities. The State HERR program will meet with the State Epidemiologist to identify specific methods local agencies can utilize to assess the prevalence of risk factors. All appropriate survey instruments and data collection procedures will be utilized on a selected communitywide basis. The State HERR program will meet with the Health Data Services Program, Neighborhood Health Center, Chronic Disease Services Program, and the Medical Society of New Jersey in order to establish policies with regard to ascertaining morbidity data and improving surveillance statewide. Managerial insight, inservice training, and other needed technical assistance will be provided to local intervention projects.

NEW MEXICO

81P-0589
Health Education-Risk Reduction (HERR) Grant Project, New Mexico.
Pendley, L.
Health and Environmental Department, Health Services Division, P. O. Box 968, Santa Fe, NM 87503
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in New Mexico was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. A computerized inventory prepared by United Way will be distributed to State district health educators for evaluation of its usefulness, accuracy, and completeness. Evaluation of this inventory will also be requested from HSA's subarea planners and the New Mexico Cooperative Extension Service. Suggestions and recommendations for updating resource information or changes in directory content or format will be solicited. Plans to distribute resource information to the public will be made. A series of district level conferences will be held to establish liaison and initiate discussion and action towards "an organized approach." Actions that will lead to the adoption of a common data set of risk factors will be discussed and initiated at these conferences. An advisory committee, an intradivisional task force, personal visits, and a bimonthly publication will also be used to link HERR efforts. In cooperation with other State agencies, the State HERR program will develop a risk factor questionnaire. Technical assistance will be provided to agencies and organizations wishing to use the questionnaire. Data processing and analysis will also be provided by the State HERR program. Existing sources of morbidity data will be identified. The HERR program director will participate in discussions with other State agencies on the establishment of a larger collection system. District conferences, inventory, personal visits, and development of a risk factor data collection instrument will be provided by State HERR program. Health promotion and risk reduction information and materials will be cataloged. A system for lending materials will be established on a district level. The need for the acquisition of new educational and informational materials will be evaluated.

81P-0590
Health Education-Risk Reduction Program at the Santa Fe Vocational Technical High School.
Francis and Sobel Associates, Santa Fe, NM
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program at the Santa Fe Vocational Technical High School is designed to (1) increase knowledge and understanding among the target population (650 students at the school) of the health risks

involved with cigarette smoking and alcohol abuse; (2) provide the necessary information for students to make decisions to eliminate cigarette smoking and alcohol abuse; (3) develop a continuing, self-sustaining school-based nutrition and health education program focusing on the prevention of chronic disease patterns; (4) increase self-esteem, decision-making abilities, and communication skills; (5) increase understanding of how the home, community, school, and natural environments affect daily decisions; (6) have participating families structure their home environment to reduce stress and promote health and nutrition; and (7) have other schools within the Santa Fe and other State school districts adopt the successful components of the program. To accomplish these goals, the program will (1) determine prevalence of cigarette and alcohol use and other risk factors; (2) train teachers and staff at the school; (3) develop curricula and devise an evaluation plan; (4) establish linkages with appropriate community organizations; (5) implement the nutrition and health education curriculum, the stress reduction curriculum, the physical exercise curriculum, the adventure education program, and the family involvement program; and (6) identify community resources available for referral of students and families. Evaluation will be conducted through (1) development of a survey instrument; (2) use of experimental and control groups; and (3) pre- and post-tests of knowledge, attitudes, prevalence of risk factors, school attendance, and relevant lifestyle behavior.

81P-0591
Zuni Health Education-Risk Reduction Program.
Pueblo of Zuni, Zuni School District, Zuni, NM
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Zuni Health Education-Risk Reduction Program is designed to (1) provide health information and alternatives to the target group (200 11th grade students at Zuni High School); (2) create a more coordinated, community-based educational approach reducing the incidence and prevalence of the major health problems of the Zuni; (3) enable 11th graders to develop skills to integrate health information with their lifestyles; (4) enable them to demonstrate the capability to identify, analyze, and synthesize health knowledge and related experiences; (5) enable them to develop attitudes to make decisions beneficial to the health of both the individual and the community; and (6) enable them to improve their coping skills and self-esteem, and develop sufficient assertiveness to assist in peer counseling, teacher training, and other health education activities. To accomplish these goals, (1) at least two teacher workshops will be conducted throughout the school year, with special attention to health-education-related topics; (2) the staff will become familiar with the goals, objectives, and general mission of the project; (3) specific training sessions will be conducted by the staff (for staff) by demonstrating experiential learning methods and techniques; (4) specific training sessions will be conducted to provide the staff with skills and awareness of public health principles and practices; (5) conferences will be given for community service providers; and (6) curricula will be based on what students need and want to know. Included will be group activities; service-oriented projects; skits, dramatizations, and experimentation with videotape; rap sessions; teen clinics; drop-in centers; summer employment; and field placements. For evaluation, social and epidemiological data will be gathered in coordination with the Indian Health Service Program Planning Division of the Albuquerque Area, and with the New Mexico Health Systems Agency. Evaluation systems of tribal programs will also be used. A community-based needs assessment will be conducted as needed. Program evaluation will be conducted by pre- and posttesting of health knowledge. Teachers will evaluate the inservice training sessions. Various pretested health education data-collection instruments will be used.

NEW YORK

81P-0592
Health Education-Risk Reduction (HERR) Grant Project, New York State.
Rothenberg, R.
New York State Department of Health, Empire State Plaza, Tower Building--6th Floor, Albany, NY 12237
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in New York State was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The HERR program will perform resource inventories in four communities that offer an organized approach to risk reduction. By May 15, 1981, inventory guides will be distributed to providers

that have responded to State-level agencies of the American Cancer Society, the American Heart Association, the American Lung Association, and other interested parties. The HERR program will conduct three meetings of the Program Advisory Council to review progress of the statewide program. By January 30, 1981, the programs will provide Advisory Council members with an evaluation of the development and implementation of intervention projects and discuss stimulation of additional communities willing to undertake an organized approach to risk reduction. The HERR program will collect risk factor incidence and prevalence data statewide and in each community where a funded project is utilizing an organized approach to risk reduction. By May 15, 1981, demographic and incidence and prevalence data on the community being served will be provided to the Project Supervisor and to the local units of the American Cancer Society, the American Heart Association, the American Lung Association, the State and local health department, and other interested parties. The HERR program will improve access to morbidity and mortality data and establish a system for recording risk factor trends, and will identify morbidity and mortality surveillance systems currently existing within communities undertaking an organized approach to risk reduction. The HERR program will provide consultation, evaluation, and assistance to the seven communities undertaking an organized approach to risk reduction on no less than a monthly basis. By June 15, 1981, the State will have performed five onsite visits with ability to provide cumulative evaluation information. By September 15, 1981, the State will have performed nine on-site visits resulting in description of the first year's accomplishments, deficiencies, and corrective action taken. The HERR program will stimulate development of an organized approach to risk reduction that will target highly susceptible minority populations in 12 communities. By January 15, 1981, the State will stimulate creation of a local Advisory Council consisting of four or more agencies with experience or expertise in lifestyle modifying health education programming. The State will develop a cooperative agreement with Rensselaer Polytechnic Institute (RPI) to provide technical and managerial consultation to the State program and each Federally funded intervention project.

81P-0593
Health Risk Reduction Program Intervention Project: Project CHARLIE (Chemical Abuse Resolution Lies in Education).
New York Dept. of Health, Health Risk Reduction Program, NY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Project CHARLIE is designed to (1) develop, implement, and evaluate a school-based program to deter the target population (1,000 Jefferson County elementary school students) from smoking and alcohol use through effective education; (2) provide young people with the opportunity to make informed decisions about alcohol use and smoking that will positively affect their health and well-being; and (3) give nonusers guidance and practice in personal skills and competencies so that they may be better prepared to enter junior high school. To accomplish these goals, the program will (1) gather base-line data using the Centers for Disease Control's common data items in a sample of students in grades 7-12; (2) implement the prevention program for a 35-week school year, on a once-weekly schedule in elementary schools to reach at least 1,000 children; (3) measure self-esteem, cognitive learning, problem-solving skills, and other pre- and postprogram measures of program effectiveness; (4) sample community attitudes, knowledge, and behavior; (5) provide school and community awareness programs; (6) as participants reach junior high, measure them against base-line data to determine the success or failure of the intervention program; and (7) recruit and train additional staff to expand the program, conduct workshops, and train peer counselors. For evaluation, the program will (1) collect base-line data for a fifth-year comparison, (2) conduct pre- and posttests of participating students, (3) conduct teacher-student interviews; and (4) sample test and control groups.

81P-0594
Health Risk Reduction Program Intervention Project: School-Home-Industry Primary Prevention Program (SHIPP).
New York State Dept. of Health, Health Risk Reduction Program, NY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The School-Home-Industry Primary Prevention Program (SHIPP) is designed to (1) provide an intensive alcohol-tobacco education program for elementary and middle school students with family, community, and industrial involvement at the primary prevention level; (2) aid the target population (students in grades 4-5 from 12 elementary schools and in grades 6-7 from 1 middle school) and their parents to better understand the role of the family and the community in the prevention of alcohol abuse; (3) enhance the target population's awareness of responsible decision making regarding alcohol and tobacco; (4) increase family awareness of alternatives for the use of alcohol as a coping mechanism; (5) provide students with

information regarding organizations that aid families of alcohol and tobacco abusers; (6) help develop continuity in health education throughout the elementary school curriculum; and (7) develop a longitudinal analysis of SHIPP based on studies conducted during the fifth year of the Health Education Risk Reduction Program Grant with students in the two local high schools. To accomplish these goals, the program will conduct workshops for faculty and community, train a task force to implement the program, distribute teaching packages for the task force, develop a broad base of support via additional curriculum materials, expand SHIPP to include additional elementary schools, initiate the classroom teaching phase, and develop additional materials. Evaluation will be conducted through (1) student pre- and postprogram knowledge surveys; (2) pre- and postprogram attitude assessments; (3) teacher program evaluation from daily logs; (4) teacher performance evaluation through class observation; (5) general program observation in a brief written report by the principal; and (6) followup student attitudinal and knowledge surveys in grades 6-7.

81P-0595
Prevention of Smoking and Alcohol Use With 7th Grade Students.
New York State Department of Health, Health Risk Reduction Program, for the American Health Foundation, NY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Prevention of Smoking and Alcohol Use With 7th Grade Students is designed to (1) conduct an intervention in an inner-city New York school system with a large proportion of minority students, with seventh graders as the target population; (2) deter onset of cigarette smoking and alcohol use, particularly heavy drinking; (3) integrate smoking and alcohol prevention components with health education emphasizing decision making and positive health values; (4) cover informational and affective aspects of smoking and alcohol use; (5) obtain new knowledge about inner-city parents' values about children's smoking and alcohol use and how parents communicate these values to their children; (6) encourage parent participation through a parent-child communication training workshop; (7) produce smoking and alcohol prevention curriculum materials that can be used by school teachers without extensive training; and (8) plan for longitudinal continuation of the program through recruitment of peer leaders and encouragement of student influences on school health policy. To accomplish these goals, (1) a 1-day teacher workshop will be held at the beginning of each semester, concentrating on curriculum activities; (2) limited medical screening will be included as a preliminary to the Know Your Body health education curriculum; (3) the general health education curriculum will include behavioral objectives, unit goals, background material, basic concepts for students to master, suggested learning activities for classroom participation, home activities with parents, and resource materials that teachers can use for reinforcement; (4) a 4-week smoking prevention component will address social and psychological factors that influence young people to smoke, and provide understanding of the immediate and long-term physiological consequences of smoking; (5) the 4-unit alcohol prevention curriculum will cover facts about alcohol use and abuse, coping skills, self-control, and values clarification; (6) a parent-child communication training workshop will increase parents' ability to communicate with their children; and (7) evaluation data from approximately 30 experimental classrooms and 10 control classrooms will be compared to determine the impact of the intervention on students' health knowledge, behavior, and attitudes. For evaluation, there will be two experimental groups (complete intervention and educational intervention) and one control group. The complete intervention group will receive medical screening, the curriculum, and the parent-child communication training workshop. The educational intervention group will not receive communication training. The control group will receive medical screening only. Evaluation for the first year will use pre- and post-tests, consisting of a health knowledge questionnaire, a health attitude survey, a habits survey, clinical measurements, a teacher-monitoring scale, parent satisfaction scale, and a parent-child perception survey.

81P-0596
Smoking and Alcohol Prevention Through Life Skills Training.
New York State Department of Health, Health Risk Reduction Program, NY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Prevention Through Life Skills Training program is designed to (1) reduce the number of new smokers and drinkers in 5 successive cohorts of seventh grade students in the target population (4,000 minority seventh graders from 9 school districts, and their teachers and parents) by 60 percent; (2) maintain a 50 percent reduction in the onset of cigarette smoking and alcohol use; (3) significantly decrease pro-smoking and pro-alcohol-using attitudes; (4) reduce the prevalence of cigarette smoking among teachers and parents; and (5)

conduct a community survey to assess the prevalence of smoking and alcohol use using the Centers for Disease Control's common data items. To accomplish these goals, (1) a two-level approach will be utilized: (a) individual intervention using the Life Skills Training (LST) program, and (b) intervention in the immediate social environment; (2) a multiple time series design will be established, with individual target schools assigned to 5 different conditions, 3 treatment and 2 control; and (3) approximately 800 seventh graders will be assigned to these conditions, which include the Life Skills Training program, schoolwide support activities, community activites, and pre- and posttests. To determine the effectiveness of the intervention at the end of the first year, the primary and control groups will be compared for (1) nonusers becoming users, (2) experimental users becoming regular users, and (3) moderate users becoming heavy or problem users. Chi-square analyses will be utilized, and smoking and alcohol use will be evaluated separately. Knowledge, attitude, and personality variables will be measured with the use of pre- and posttests. Parent-teacher smoking status will be assessed by questionnaire and the use of nonparametric statistics.

81P-0597
Student Health Intervention Program.
Westchester County Department of Community Mental Health, White Plains, NY
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Student Health Intervention Program has two components. The Alcohol Program is designed to (1) reduce the number of new cases of high school students whose alcohol use causes them difficulty in their daily lives; (2) reduce the number of high school students with nonsevere alcohol disabilities; and (3) test alcohol prevention strategies on a significant number of students. The Smoking Program is designed to (1) provide students with the necessary skills to resist direct social pressures to smoke; (2) decrease susceptibility to indirect social pressure to smoke by promoting the development of greater autonomy, self-esteem, and self-confidence; (3) enable students to cope with anxiety, particularly that induced by social situations; (4) increase students' knowledge about the consequences of smoking; and (5) promote the development of antismoking attitudes and beliefs. To accomplish the goals of the Alcohol Program, (1) non-alcohol-abusing students with alcoholic parents will meet once a week in educational and supportive group sessions; (2) students who do not show evidence of alcohol abuse will be seen for two sessions to determine if there is alcohol involvement by students or parents; and (3) students with inappropriate or episodic use of alcohol will be referred to a program counselor. In the Smoking Program, (1) a tobacco education curriculum will be implemented in each of five target schools, with each student required to take a one-semester course; (2) program counselors will be trained; (3) community organization and coordination will take place, with student referrals to outside smoking clinics and widespread publicity about the implications of tobacco use; and (4) parents will be kept informed of all activities to help them understand the influences and pressures on young people that lead them to smoke. The target group will be selected from five Westchester County high schools. Process and outcome evaluation will be utilized to determine the program's effectiveness in reducing alcohol abuse, cigarette smoking, and related problems in the school. The Department of Community Mental Health's Office of Evaluation and Research will monitor the program. Each area will be evaluated with the help of information management system questionnaires, surveys, and statistical tests.

NORTH CAROLINA

81P-0598
Health Education-Risk Reduction (HERR) Grant Project, North Carolina.
Cosby, M.
North Carolina Department of Human Resources, Division of Health Services, Health Assurance Section, P.O. Box 2091, Raleigh, NC 27602
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in North Carolina was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. A survey instrument designed by the project manager will be mailed to hospitals, industries, and other selected organizations. Follow-up will be conducted by mail and by telephone to ensure that at least 75 percent of the questionnaires are returned. By July 1981 data about HERR activities in North Carolina will be available to 85 percent of those who request it. By

December 1980 the applicant will establish liaisons with key agencies and organizations in North Carolina involved with or interested in risk reduction activities. A progress report on the HERR project will be prepared by the project manager every 6 months and sent to appropriate organizations. After the project manager has reassessed the HERR program's needs, appropriate organizations will be asked to provide technical assistance. By November 1980 the applicant will have completed the design, evaluation, and selection of survey methods to be used in determining the prevalence of risk factors for chronic disease in selected communities and populations. Existing sources of data on prevalence of risk factors will be identified, and by July 1981 methods to improve surveillance for risk factors will be determined. By November 1980 the project manager will meet with representatives of various public and private groups to discuss ways to improve the collection of data on morbidity. By February 1981 sources of data on chronic disease morbidity in North Carolina will be identified. Project staff will determine ways to improve surveillance for such data by July 1981. Counties conducting HERR projects will continue to receive technical assistance from the applicant and will be visited at least once during the year by the project manager. By February 1981 procedures for monitoring local HERR activities will be developed and put into effect.

81P-0599
Franklin County Health Education-Risk Reduction Project.
Franklin County Health Department, Louisburg, NC
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Franklin County Health Education-Risk Reduction Project is designed to (1) maintain the current low rate of smoking in the target population (1,558 students in grades 4-7 in Franklin County schools, 54 percent of whom are black) through October 1981; (2) maintain the current low rate of alcohol consumption in the target population through October 1981; and (3) effect the following changes by 1985: (a) 88 percent of the seventh graders will not adopt smoking or drinking behaviors; (b) 5 percent of those smoking will change to low tar-nicotine cigarettes, and 5 percent of those drinking will reduce their consumption; (c) 10 percent of those smoking will reduce their daily number of cigarettes smoked; and (d) 10 percent of those smoking or drinking will stop. To accomplish these goals, the program will (1) develop and implement a youth board under the guidance of a program representative, to discuss, design, and evaluate the most appropriate method of meeting student-identified needs with regard to smoking and alcohol abuse; (2) coordinate local health resources to strengthen the educational process; (3) conduct teacher training, with emphasis on a positive attitudes approach; (4) design curricula to include activities to explore the influences that may encourage or discourage smoking, such as peer pressures, role models, adolescent rebellion, curiosity, and the need to compensate for underachievement in areas important to students; (5) implement the curriculum in grades 4-5 by 1982 in a minimum of five elementary schools; and (6) develop a curriculum to meet the needs of students in grades 6-7. The evaluation standard will be that 85 percent of program objectives will be completed by the date indicated.

81P-0600
Health Education-Risk Reduction Program.
Buncombe County Schools and Asheville City School, Asheville, NC
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program is designed to (1) encourage the youth of Buncombe County to make responsible decisions concerning drinking and smoking, and (2) reduce the prevalence of smoking and alcohol use and the related problems among children and adolescents. The program will be conducted through (1) Centers for Disease Control guidelines used in the development of a survey for grades 4-11; (2) a random survey of 5 percent of adults in Buncombe County; (3) a curriculum for grades 1 and 4, including a puppet show or skit as a stimulator activity in grade 1 and Health Adventure's substance abuse program in grade 4; (4) programs for grades 7 and 10 designed to be multidisciplinary, including peer education for grade 10 and a panel of professional consultants to design a stimulator activity; (5) training of 75 percent of teachers; (6) organization of committees for communications, legislative action, education, program review, and community presentations; (7) distribution of a catalog of community resources for smoking education and cessation, and for alcohol education and counseling; (8) development of a plan for increasing youth participation in leisure-time activities provided by community organizations; (9) smoking cessation clinics at seven school sites; (10) a possible "don't drive home drunk" hotline; and (11) a media campaign. The target group will consist of students in grades 1, 4, 7, and 10 in Buncombe County Schools and Asheville City Schools, and parents and youth in Buncombe County communities. Evaluation will be conducted through (1) needs assessment prior to program implementation and continual surveying thereafter; (2) accomplishments determined according to specific ob-

jectives; (3) record keeping of participation in groups and workshops; and (4) study of records of agencies, such as the police, for indication of a change in accident prevalence.

81P-0601
Health Education-Risk Reduction Program.
New Hanover County Health Department, NC
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program is designed to (1) ensure that 20 percent of reproductive-age women reduce alcohol consumption to a safe daily level, and that 5 percent stop drinking altogether; (2) inform women of dangers alcohol presents to the fetus, and the safe daily amount of alcohol during pregnancy; (3) provide information on alcohol consumption, social supports, and bodily functions; (4) identify the prevalence of alcohol use by intake histories; (5) conduct inservice training regarding the incorporation of information on alcohol use in intake histories; (6) conduct a workshop to identify available resources and service agencies; (7) conduct a training program involving agencies working with women who abuse alcohol; (8) ensure that women who smoke 20 or more cigarettes per day change to low tar-nicotine cigarettes and that 5 percent stop smoking; (9) ensure that 5 percent of women select contraceptive methods other than birth control pills, and provide information on the dangers of smoking while taking birth control pills; (10) make women aware that smoking can adversely affect the fetus; (11) record smoking habits of 90 percent of women, and train staff to incorporate smoking behavior in intake histories; (12) inform 50 percent of women about smoking cessation programs, and design and offer these programs; (13) help students in grades 5-6 make responsible decisions about personal health habits, including smoking and alcohol use; (14) establish a council of school principals, teachers, and health education staff; (15) establish a student council of an advisor and students in grades 5-6 and 10-12; (16) present classes to students on decision-making processes and the effects of smoking; (17) prepare students to make presentations to classes and community groups; (18) provide joint sessions for students and parents, and inform students of the value of support systems and positive role models; (19) ensure that health department employees reduce cigarette consumption, and that 5 percent stop smoking; (20) encourage health department employee participation in smoking cessation clinics; (21) convince health workers not to smoke in the presence of patients; and (22) provide employees with information on influencing smoking habits of health care providers outside the health department. The program will be conducted through (1) staff training; (2) health education units for women who smoke or abuse alcohol; (3) group meetings; (4) establishment of clusters of participants for quitting smoking, reducing smoking, or changing to low-tar and -nicotine cigarettes; (5) smoking cessation clinics for women; (6) referrals to community health services for further needs of participants; (7) outreach contacts for reinforcement; (8) recognition awards; (9) workshops for teachers, counselors, ministers, Sunday school teachers, parents, and senior students; (10) classroom units; (11) pre- and posttests administered to students; (12) demonstrations, role playing, and games; (13) health education units in Sunday school classes and community groups; (14) classroom councils, individual sessions with students after school hours, student-parent conferences, outreach contact for reinforcement, and merit awards; (15) health education units for department staff; (16) provision of information to health care providers; and (17) a no-smoking "buddy" system to include at least two health care providers outside the health department. Prevalence of risk factors will be documented in health department patient records, using common data items, and will be consistently applied as part of the intake histories for the target population. Pre- and posttests will identify changes.

81P-0602
Youth Exploring Alternatives for Health (YEAH!) Project.
Guilford County Department of Public Health, NC
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Youth Exploring Alternatives for Health (YEAH!) Project is designed to (1) deter the early initiation of smoking and drinking patterns among adolescents; (2) establish base-line data on health problems and behaviors; (3) document the prevalence of risk factors and methodologies designed to lower these risk factors through surveys; (4) provide alternatives to detrimental health practices among adolescents, communication skills for teenagers and their parents, social support systems, improved self-concepts, decision-making and coping skills, and training to health department and other agency personnel; (5) foster cooperation among community agencies and citizens; (6) strengthen health education curriculum components; (7) encourage pregnant teenagers not to drink or smoke; (8) provide additional training for school personnel in teaching decision-making and coping skills and substance abuse information, and encourage school personnel to examine their own attitudes; (9) achieve a 2 percent re-

duction in smoking among youth, and in the number of cigarettes smoked per day for heavy smokers; (10) achieve a 4 percent reduction in alcohol use among students; (11) achieve a 10 percent reduction in smoking among pregnant women; and (12) achieve a 20 percent reduction in drinking during pregnancy. The program will be conducted through (1) special curriculum supplements and other resources on smoking and alcohol, to cover decision-making and coping skills and building of self-esteem; (2) community interventions involving collaboration with recreation, health, and church organizations, and the media; (3) family planning-maternity health education; (4) group activities to promote healthful attitudes and practices so that youth are less influenced by peer pressure and negative role models; (5) workshops in local churches to enhance communication skills between teenagers and their parents, with similar workshops for junior high school students and their parents organized through parent-teacher associations and offered annually at three schools, (6) an interagency committee of professional resource people developed to conduct alcohol- and tobacco-related programs for 10- to 15-year-olds; (7) a patient education program on smoking and drinking for pregnant teenagers who attend maternity clinics at Warnersville Community Health Center; and (8) extensive training for health education teachers in selected junior high schools in developing positive self-concepts, communication skills, effective education techniques, alternatives to drug use, and the physiological and mental effects of alcohol and tobacco substances on the body. The primary target groups will consist of Warnersville 10-to 15-year-olds and pregnant teenagers 19 years old and under from the maternity clinic. The population is predominantly black. The program will be evaluated through process evaluation; impact evaluation using pre- and posttests of participant knowledge, attitudes, and practices; and outcome evaluation via a community survey of risk factor prevalence.

NORTH DAKOTA

81P-0603
Health Education-Risk Reduction (HERR) Grant Project, North Dakota.
Eisenzimmer, M.
North Dakota State Department of Health, Capitol Building, 17th Floor, Bismarck, ND 58505
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in North Dakota was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. To expand and update the inventory, a questionnaire on HERR programs and services will be mailed to each of at least 600 agencies and organizations. Program staff will contact each organization for which the questionnaire is missing or incomplete. By August the directory will be printed and distributed to all those requesting a copy. The Interagency Council on Smoking and Health will meet at least two times and will begin implementing its objectives. Project staff members will establish liaison with the Department of Public Instruction and will hold at least six meetings with department staff members. The State will maintain liaison with the public and private agencies already supporting it. Before and after the school smoking prevention program, a survey will be conducted of the smoking habits and attitudes of 4,500 students in grades 5, 7, and 10 in 3 different communities. This process will involve testing, developing a questionnaire, scheduling, survey methods, computerization, and analysis. A report on the survey's results will be distributed to all school districts participating in the survey. Project staff will identify 75 percent of the sources for morbidity and mortality data on diseases related to smoking and alcohol use. A questionnaire will be developed and mailed to all agencies involved in collecting this or related data. Any agency whose questionnaire is missing or incomplete will be contacted. Using this information, the format for a data collection system will be designed. In September the Project Director and the Director of Health Statistics will discuss the data collecion system with the agencies that will be participating. Project staff will continue and expand a smoking education program for 5th, 7th, and 10th graders in Bismarck and Minot; 2,900 students will be involved. The HERR project will provide technical assistance to at least 20 agencies and organizations and encourage them to establish their own risk reduction projects. Each community receiving a grant will be visited at least twice, and the progress of each intervention activity will be documented.

OHIO

81P-0604
Health Education-Risk Reduction (HERR) Grant Project, Ohio.
Stamm, M. F.
Ohio Department of Health, Division of Communications, 246 North High Street, Columbus, OH 43216
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Ohio was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By September 30, 1981, the HERR staff will conduct and be maintaining an inventory of at least 15 State-level agencies or organizations that are addressing HERR. By November 1980 the staff will inventory each pertinent division of the Ohio Department of Health including Communicable Diseases, Chronic Diseases (smoking, cancer, hypertension, and diabetes), Alcoholism, Nutrition, Maternal and Child Health, and the Accident Prevention Unit, and by March 1981 each key State agency of the Public Health Association, Society for Public Health Education, Department of Education, American Heart Association, American Lung Association, American Cancer Society, Medical Association, Cooperative Extension Service, and March of Dimes, etc. An annual update will be conducted, and by March 1981 a mechanism for handling inventory inquiries will be implemented. The inventory information will be disseminated to State-level organizations and agencies. By September 1981 at least four metropolitan and eight rural communities will also conduct and maintain an inventory based on a survey tool explained to community representatives in November 1980, and in a training session by December 1980 and to a list of agencies compiled by the communities by December 1981. The inventory will be publicized and disseminated through a wide range of communications--churches, libraries, media, Welcome Wagon, Chamber of Commerce, etc. By September 1981 the staff will complete an inventory of HERR activities in 90 percent of Ohio's 88 county health districts. By May 30, 1981, the staff will develop and maintain working relationships with agencies and organizations involved with or interested in risk reduction activities on the local, regional, departmental, and State-level to promote HERR efforts in Ohio. Local efforts will include presenting program rationale, concepts, and goals to 90 percent of county health departments by September 1981. Regional efforts will include establishing at least four HERR councils (one per ODH district) and have met at least three times to facilitate communication and stimulation of programs. Interdepartmental efforts include working with the Interdepartmental Task Force of the ODH at least six times. Statewide efforts will include working with at least 10 State-level organizations to present the program and to coordinate and promote efforts to meet the "1990 Objectives for the Nation." Inventory information will be made available to these agencies. By 1981 the HERR staff will submit at least one article on the program to a State newsletter as well to determine the feasibility of a State HERR newsletter. By December 1980 HERR staff will send out the CDC-recommended Common Data Items survey tool and rationale to communities with funded intervention proposals, to HSA's, and to appropriate State agencies. By January 1981 the staff will conduct workshops to assist funded communities to implement a survey tool; surveys will be completed by April 1981. Survey forms will be processed by ODH. During May 1981 the State will assist communities in interpreting data; by September 1981 at least four nonfunded communities will be assisted in conducting a Common Data Items Survey and in interpreting results. By September 1981 the staff will interview agencies involved in chronic disease morbidity and mortality and risk factor data gathering. By December 1980 a list of agencies will be compiled and by January 1981 the staff will design an interview form which will include questions regarding existing mechanisms for data collection, type of data collected, and accessibility of data for other agencies. By September 1981 the staff will investigate the feasibility of developing a standardized system of chronic disease morbidity and mortality and risk factor data collecting by reviewing and categorizing existing data; consulting, analyzing, and discussing future program objectives; surveying agencies regarding the types of data needed; and discussing and consulting with State chronic diseases and epidemiology staffs about possible techniques to improve surveillance and the feasibility of standardizing data collection techniques. HERR staff will continue meeting with county health departments to inform them of the characteristics of an organized approach and will have met with 90 percent of the State's 88 counties by September 1981. Priority funding for intervention proposals will go to communities utilizing an OARR. Staff will work with HSA's to document communities undertaking OARR and by June 1981, 12 will be identified. The staff will develop an identifiable strategy for stimulating communities to continue an OARR.

81P-0605
Eastern Ohio Preventive Health for Youth--A Health Education Risk-Reduction Program.
Martins Ferry Health Department, Martins Ferry, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Eastern Ohio Preventive Health for Youth program is designed to (1) reduce alcohol consumption and smoking among 12- to 17-year-olds; (2) reduce the weight of obese students; (3) increase the number of 12- to 17-year-olds participating in regular physical activities; and (4) increase hypertension detection by 50 percent and treat 70 percent of the sufferers over the long run. To accomplish these goals, the program will (1) survey for the incidence of risk and occurrence of alcohol use, smoking, obesity, hypertension, and lack of exercise; (2) conduct a media campaign; (3) cooperate with local agencies concerned with the same problems; (4) concentrate awareness of these conditions and their ramifications on the target group (all students in grades 3, 6, 9, and 11 in Martins Ferry); (5) train teachers to conduct the "Here's Looking at You" program on alcohol abuse and a smoking cessation program; (6) tailor fitness and weight reduction programs to individuals and conduct exercise classes at Martins Ferry Recreation Center; and (7) twice a year, conduct "lock-ins"--intensive overnight courses, one concentrated on alcohol use and one on smoking--with 300 youths. Surveys taken throughout the year will be compared with a set of surveys taken at year's end. Changes in behavior and attitude throughout the year will be noted, and project directors will note the number of educational materials distributed, blood pressures read, articles in newspapers, and radio and TV appearances. The pattern of financial disbursements may also be monitored. A random phone survey will be conducted to determine the success of the media campaign, and the survey tool developed by the Centers for Disease Control will be used to determine any change in the selected target groups.

81P-0606
Greenfield, Ohio, Adolescent Health Risk Reduction Program.
Greenfield Municipal Hospital, Greenfield, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Adolescent Health Risk Reduction Program is designed to reduce health risks associated with tobacco, alcohol, and drug abuse by implementing an adolescent health risk reduction program for the 1,079 students in grades 5-10 in the Greenfield Exempted Village Schools. To accomplish this goal, the program will (1) redesign the school's health curriculum to increase student knowledge and health skills in substance abuse risk reduction; (2) develop an inservice training module for school administrators, teachers, nurses, and other support staff to improve the quality of instruction and skills in substance abuse risk reduction; (3) develop a smoking cessation module; (4) provide alcohol and drug abuse services; and (5) encourage community-level efforts in reinforcing positive health behaviors in substance abuse risk reduction. Principal questions to be addressed in evaluation include (1) does participation in substance abuse risk reduction programs increase the awareness and knowledge of relevant risk factors among adolescents? (2) does participation in a risk reduction program alter the likelihood that an adolescent will choose risk-decreasing instead of risk-increasing lifestyle habits? and (3) does participation alter the observable behavior of individuals in such a way that chronic health risk is reduced? Data collection techniques will include documents analysis, in-person and telephone interviews, and automated and manual searches of Greenfield Municipal Hospital records and those of the schools and other local participating institutions.

81P-0607
Health Education-Risk Reduction "Physical Fitness Alternative."
Cincinnati Department of Health, Cincinnati, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The "Physical Fitness Alternative" is designed to (1) reduce smoking and alcohol use among the target group (students in grades 5-6 in the Cincinnati City School District); (2) test the hypothesis that physical fitness status is a vehicle for promoting positive changes in health behavior; (3) test the hypothesis that lifestyles are amenable to change through education; (4) test the hypothesis that early intervention will facilitate prevention of alcohol and tobacco abuse or make remediation easier; (5) improve attitudes toward smoking and alcohol in half of the target group; (6) increase knowledge of the effects of alcohol and tobacco upon health among half of the target group; (7) improve health-related physical fitness, as measured by cardiovascular function, body composition, strength, and flexibility, in half of the target group; and (8) significantly improve self-reported behaviors of teachers and other school personnel concerning alcohol and tobacco risk reduction. To accomplish these goals, (1) students will develop individual health goals and begin working toward

them; (2) health educators who provide intervention in the classroom will develop the aggregate of students in a particular class into a support group to reinforce individual members in positive health behaviors; (3) participants will be presented with information and involved in discussion on the negative effects of alcohol and tobacco use and the benefits of physical fitness; (4) high risk students will be assisted in developing social problem-solving skills; (5) those participating in the treatment will be exposed to positive health models by educators providing the intervention as well as by field trips and invited guests; (6) students who improve their health and physical fitness status will receive formal recognition; and (7) inservice training will be provided for staff in schools. For evaluation, a preprogram telephone survey to determine smoking and alcohol use and an instrument to select high risk students will be employed. The latter instrument will then be readministered at the end of the program. In addition, the first year evaluation calls for a process evaluation which will determine how closely implementation follows the conceptual model. More elaborate evaluations are planned for subsequent years.

81P-0608
Health Education-Risk Reduction Program.
Akron City Department of Health, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program is designed to (1) decrease selected destructive lifestyle behaviors--smoking, alcohol abuse, poor nutrition and overeating, lack of exercise, lack of knowledge to deal with stress--and increase health-promoting lifestyles among the target population (1,002 students in 1 junior high school and 892 students, along with their parents, in 1 high school, and 103 teachers at the 2 schools; students in another junior high school and high school will act as the control group); (2) obtain data on risk factor prevalence; (3) reduce fragmentation of existing health education programs; (4) change the behavior of at least half of the students and teachers in at least 1 of the 5 risk areas; and (5) change the behavior of at least 15 percent of students' parents in 1 of the 5 risk areas. To accomplish these goals, the program will (1) provide workshops on effective lifestyles for teachers, administrators, and counselors; (2) create curriculum development teams representing departments of health, physical education, science, and home economics; (3) administer pretests to students; (4) implement the curricula on a pilot basis; (5) evaluate and make necessary modifications in the pilot programs over the summer, and develop curriculum guides in preparation for full implementation the following school year; (6) provide workshops for teachers on new curriculum programs; (7) create a risk reduction extracurricular-activities team to make a preliminary inventory of risk intervention services for youth and report on gaps in those services or their inappropriateness for the target group; (8) create new intervention services as needed, based on that report; (9) implement at least one new pilot risk reduction intervention service for each risk area; and (10) after evaluation of pilot intervention services, institute them on a regular basis. Pre- and posttests will be used for evaluation. Extracurricular risk intervention programs may incorporate a "Self-Care Plan Contract" to monitor participants' plans for altering risk behavior and to measure impact. The use of a control group will allow for an analysis of cognitive, attitudinal, and behavioral differences between the two groups.

81P-0609
Health Education-Risk Reduction Project for the Galion School District: "Organized Community" Approach.
Community Counseling Services, Inc., OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The "Organized Community" Approach is designed to (1) make 25 percent of the Galion School District population aware that smoking is a major risk factor in cancer, respiratory illness, and heart disease; (2) make 25 percent of the population aware of the fetal alcohol syndrome; (3) increase the number of women, infants, and children who participate in nutrition education programs; (4) encourage the development and expansion of physical fitness programs that are accessible to the school population; (5) encourage the presentation of at least one community program to the school population on stress; (6) encourage the delivery of at least one annual hypertension screening clinic; (7) increase the awareness of overweight persons in the school population of the health risks associated with obesity; (8) implement Project Sunshine for grades K-6 and the Troubled Student Program for high school students; (9) hold a health awareness week to enhance the linkage between school-based activities and the program approach to health risk reduction; and (10) expand Project Sunshine and the Troubled Student Program during years 2-3. To accomplish these goals, the program will conduct (1) a prevalence survey on health risk behaviors within the school district; (2) Project Sunshine, a primary prevention program of curriculum activities that cover increasing self-esteem, providing classroom education, training 10 teachers and 12 community volunteers to im-

prove their health-education-related knowledge, and offering values clarification and decision-making skills to participants; (3) the Troubled Student Program, with curriculum activities to reduce health risks due to alcohol, cigarette, or other drug use; the program will provide counseling services and 4 educational groups per academic year for students at risk from smoking and alcohol use, assure that students can identify health risks of their behaviors, and assure that half of school personnel participating in health risk behavior presentations increase their knowledge; (4) pre- and posttests to assess changes among participants; (5) counseling services for students and their families; (6) community volunteer involvement in preventive activities; and (7) the 5-day health awareness week as a culmination of year 1 project activities. Process and impact evaluation will be conducted, and videotapes of Project Sunshine classes will assist in process documentation.

81P-0610
Hocking Technical College Health Education-Risk Reduction Program.
Hocking Technical College, Community Health Education Center, Nelsonville, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Hocking Technical College Health Education-Risk Reduction Program is designed to (1) decrease smoking and alcohol abuse among target area youth (high risk students in grades 6 and 9, and their families, in Athens, Hocking, Perry, and Vinton Counties); (2) reduce the health risks and improve the knowledge, behaviors, and lifestyles of selected families; (3) promote the integration of risk reduction activities into the community; and (4) operate a surveillance and epidemiology system, which will detect and monitor specific conditions that contribute to morbidity and mortality and provide the data for analysis appropriate to the development of prevention and control methods. To meet the first objective, the program will (1) integrate a smoking and alcohol education curriculum into the existing health curriculum for ninth graders, combining alcohol and smoking information along with exercises designed to enhance coping and decision-making skills and values clarification, and the use of pamphlets, films, and biofeedback machines (CASPAR (Cambridge and Somerville Program for Alcohol Rehabilitation) and the curriculum developed by the 1980 Appal Corps specifically geared to Appalachia will both be used); and (2) present a shorter, modified version of the program to sixth graders with the participation of ninth graders who have completed the program. To meet the second goal, (1) the family program will be linked to the school program via the ninth graders; (2) using the wellness approach, the staff will assess family health status, formulate a problem list, develop plans, coordinate intervention strategies, and help evaluate family status; and (3) determine health status through interviews, observations, and questionnaires. To meet the third goal, the program will (1) participate in the Health Systems Agency Area 6 Health Education Task Force; (2) develop a teacher training program to transfer instructional responsibility from the project staff to the schools; (3) offer advice to and share resources with local agencies for developing health promotion activities; (4) create and operate a speakers bureau to provide lectures or presentations to community and professional groups; and (5) generate interest in an exercise-fitness trail. To meet the fourth goal, the program will (1) develop a health risk appraisal and administer it annually, and (2) communicate data to public health officials, practicing health professionals, and the community via official reporting mechanisms, print media, and visual presentations. Each of the four objectives will have its own evaluation procedures: (1) pre- and posttests will be administered to determine changes in students' knowledge, attitudes, and behaviors; followup surveys will be administered each fall; and blood pressures will be measured annually; (2) progress will be measured through comparison of baseline and current data on an ongoing basis, and health risk appraisal and sodium intake and blood pressure monitoring will be used; (3) an annual report will document activities, number of persons served, and outcomes; and (4) the health risk appraisal will be used.

81P-0611
Madison County Health Education Intervention Project.
Madison County Hospital, Inc., London, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Madison County Health Education Intervention Project is designed to (1) implement a comprehensive program of health education and risk reduction for high risk youth 12 to 18 years old in the county within 3 months of project initiation; (2) provide preventive health education services, primarily related to smoking and alcohol consumption; (3) train 15-25 adolescents, 16 to 18 years old, as lay community health advisors in a method similar to the Community Health Education Program of Duke University Medical Center or to the CASPAR (Cambridge and Somerville Program for Alcoholism Rehabilitation) model; (4) provide indirect services to an additional 100 youths through the lay community health advisors;

(5) coordinate the program through the Madison County Mental Health Center, the county health department, local junior and senior high schools, the cooperative extension service of the county, and existing alcoholism and other health planning and service agencies; (6) overcome common barriers to preventive health education programs regarding personal choice behaviors such as smoking and alcohol consumption; and (7) establish an approach to health education-risk reduction for children and youth which can be continued. To accomplish these goals, the program will (1) conduct assessment and surveys to determine risk factors; (2) overcome common youth resistance to authority opinion; (3) reach the target group in natural settings; (4) foster peer support; (5) offer concrete services as well as preventive education; (6) coordinate with other organizations; (7) provide common identification of the program with ongoing health maintenance services; (8) target messages based on individual needs; (9) create an opportunity to incorporate learning into action through observing; and (10) provide an informal, but comprehensive, approach to influencing personal choice health behaviors. For evaluation, (1) the hospital director, mental health center director, and program director will monitor the program in biweekly meetings, as will representatives of the Ohio Department of Health in quarterly meetings; (2) the Madison County Hospital will work with all health care organizations in the county, using such aids as the Model Standards for Community Preventive Health Services, to formulate goals and objectives; (3) degree of attainment of the objectives will be assessed through surveying participants, comparing survey results before and after the program, and reviewing and documenting the degree of program implementation in a written document at the end of the second quarter and at the end of the program year; and (4) quantitative assessment will be ongoing and will formally culminate in a descriptive document detailing the activities, difficulties, and impact of each activity.

81P-0612
Middletown Risk Reduction Program.
Middletown Health Department, Middletown, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Middletown Risk Reduction Program is designed to (1) provide continuity for health education programs beyond the initial funding year; (2) maximize community support for risk intervention programs through utilization of electronic and print media; and (3) educate youth about smoking and alcohol. To accomplish these goals, the program will (1) film a series of videocassettes that provide specific educational impact, and provide copies of the cassettes to each of 3 primary cooperating agencies, the Middletown Public Library for use in their reference and teen room sections, and the health department for loan to private community agencies; (5) assist the student editorial staffs of the 2 school newspapers, the Miami University Branch Campus paper, and the Middletown Journal's Saturday Teen Page in the preparation of at least 4 feature articles for each publication during the 1980-81 school year; (6) prepare tapes for a local radio station on smoking and health, accidental injury control, physical fitness and exercise, nutrition, misuse of alcohol and drugs, high blood pressure, stress and violence, and mental health; (7) develop a feature article on each major risk reduction priority for periodic publication in the community's newspaper; (8) design a pre- and posttest random telephone survey of 50 adolescents to be used prior to and following completion of the print media program; (9) provide at least 10 hours of health education consultation services per week to the Middletown School System's project; and (10) conduct a health fair for ninth graders; these students will then be sent in teams of 10 to speak to fourth graders on alcohol and smoking. The target group will consist of students in grades 4 (850) and 9 (780). An annual reevaluation of the status of risk factors in the community will be determined through a random sample survey using the Centers for Disease Control's common data items.

81P-0613
Movin' Up to Wellness.
Zanesville-Muskingum County General Health District, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Movin' Up to Wellness is designed to (1) assess the health status of individuals in the community (Muskingum County and the city of Zanesville); (2) assess the health status of the target population (all youth and high risk families in Muskingum County, particularly 120 7th graders from 2 junior high schools and 120 10th graders from 1 high school, with 60 7th graders and 120 10th graders acting as controls) through a self-assessment tool and health cards; (3) motivate the target population to adopt positive health skills; (4) provide opportunities for the target population to maintain positive health practices; and (5) reinforce preventive health behaviors. The program will be conducted through (1) a prevalence study of individual health status; (2) self-assessment to provide a holistic perspective of the individual lifestyle, with questions generally directed toward exercise, nutrition, dental health, smoking, alcohol, stress, life events, and accident preven-

tion; (3) health cards to determine the behaviors that need to be modified; (4) assessment, intervention, reinforcement, and continuation concepts; (5) the Positive Lifestyle Project, aimed at 7th and 10th graders and their families; (6) wellness clinics for youth and parents; and (7) a teen advocacy project. Evaluation will involve pre- and posttests to determine changes due to the intervention, and the Centers for Disease Control's common data items and questions to survey knowledge, attitudes, and behaviors before and after health education. Data will be compiled and computed with the assistance of Ohio University.

81P-0614
Pike County Community Action Family Health Center.
Community Action Committee of Pike County, Inc., Piketon, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Pike County Community Action Family Health Center is designed to (1) increase knowledge and reduce incidence of smoking, hypertension, alcohol use, stress, accidents, and injuries; (2) increase knowledge of nutrition and exercise; and (3) introduce good habits concerning these behaviors. To accomplish these goals, the program will (1) determine the prevalence of risk factors; (2) give four 1-hour smoking prevention sessions; (3) give six 1-hour sessions on hypertension prevention for 10- to 12-year-olds (screen 200) and 4 sessions for participants 25 to 45 years old; (4) give six 1-hour sessions on nutritional awareness to sixth graders, offer diet counseling, give six sessions to 25- to 45-year-old participants, and offer appropriate counseling; (5) devote 1-5 days to alcohol education in the classroom; (6) offer workshops on stress control to the elderly and adolescents; (7) implement an ongoing educational program on accident prevention, including vehicle fatality safety, home accident fatality prevention, mortality rate from drowning, and prevention of residential fire deaths; and (8) increase knowledge and opportunity for exercise among children 12 to 18 years old through an organized recreation program. Pre- and postquestionnaires will be designed to assess the prevalence of risk factors, as well as the knowledge, attitudes, and beliefs of the participants. The Centers for Disease Control's prevalence assessment tool will be used as the foundation of the prevalence survey geared to the participants.

81P-0615
Project Panther-2 (Prevent and Neutralize Through Health Education-Risk Reduction).
Mahoning Shenango Area Health Education Network, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Project Panther-2 is designed to (1) reduce students' specific health risks and increase positive health behaviors through educational programming emphasizing affective, cognitive, and psychomotor development; (2) help parents recognize their role in promoting positive health behaviors and work with their children in developing healthy lifestyles; and (3) help the community realize that the best means of improving health is through preventive health measures, such as health education and risk reduction. Phase I of the program will be conducted through instruction in skills involving self-awareness, relationships, and decision making. Phase II will involve utilization of skills acquired in Phase I in conjunction with cognitive information regarding specific risks. Phase III will involve development of psychomotor skills in the practical application of beliefs and knowledge acquired in the first two phases. The target group will consist of approximately 300 students in grades 5-6 in Mahoning County. Phases I and II will be evaluated using pre- and posttests. Process evaluation will be made by assessing the amount of educational materials distributed to students, parents, and teachers, and it will include assessment of field trips, health fairs, and a health education camp.

81P-0616
Rainbow Health Advocacy Project.
Mexican Americans United for Health, Inc., Toledo, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Rainbow Health Advocacy Project is designed to (1) develop, implement, and evaluate school- and community-based programs designed to deter the target group (2,011 seventh grade students in inner-city Toledo schools) from smoking and alcohol abuse; (2) provide especially vulnerable groups, particularly minority populations, their peers, and their families, the opportunity to make informed decisions on tobacco and alcohol health risks; (3) collect formulative data for use in health planning in each of 6 central-city communities; and (4) provide education in smoking, alcohol use, obesity, exercise, stress, hypertension, and accident prevention and injury control. To accomplish these goals, the program will (1) develop a

task force of health professionals and consumers for linkage development and health education activity feedback; (2) prepare and publish 500 copies of the "Information and Referral Handbook," which describes health risk behaviors, information about services, and resource contacts in metropolitan Toledo; (3) provide documentation on the prevalence of risk factors in the target population; (4) develop and conduct at least 4 education activities in each of 6 junior high schools, specifically for seventh grade health classes; (5) conduct at least 9 monthly meetings for parents of seventh grade students; (6) facilitate parental and youth volunteer organization and supervision of at least 48 family activities that are incompatible with tobacco and alcohol abuse; (7) provide home visits, counseling, and referral to a minimum of 20 participants a month in each of the 6 neighborhoods served; (8) prepare and disseminate the "Values Clarification Handbook"; and (9) prepare and provide health information and educational media to 6 neighborhoods and the community at large. Process and impact evaluations will be used. Concentration will be on specific program objectives, including changes in participants' attitudes, values, and knowledge. Monthly progress reports will be made. For the summative evaluation, a base-line with second-month eighth grade students will be established, using a random sample of 384 students. When program seventh grade participants have passed to grade 8, a random sample of 384 will be drawn in the second month and compared against the base-line sample.

81P-0617
Risk Reduction Education Program (RREP) of Logan County, Ohio.
Logan County General Health District, OH
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Risk Reduction Education Program (RREP) has two components. The Logan County Schools component is designed to (1) implement programs for students in grades 5,8, and 10, teachers, and parents on smoking, decision making, and positive self-image; alcohol and substance abuse; high blood pressure; nutrition; stress, violence, and mental health; physical fitness; and accidental injury control; and (2) reduce the number of students who smoke, drink, and engage in other risk behaviors. The Bellefontaine Schools component is designed to (1) implement the Berkeley Model (School Health Curriculum Project) in grades K-6 (1,539 students); (2) provide inservice training in the curriculum for 90 elementary teachers; (3) introduce a modification of the curriculum in grades 7-8 (415 students); (4) revise the curriculum for grades 9-12 (896 students); (5) include 750 parents in Project RENEW; and (6) reduce the incidence of alcohol, drug, and tobacco use among students. In the Logan component, the program will (1) develop and implement a substance abuse program in all schools; (2) develop and implement an alcohol education program as part of the health curriculum; (3) implement the Georgia Heart Association's "Risk Reduction--It's the Name of the Game" for eighth graders; (4) use the health book series "You and Your Heart" for primary and secondary students; (5) integrate the American Heart Association's "Putting Your Heart Into the Curriculum" into the health courses to augment material in the new books; (6) implement the Quest program in the 1981-82 school year in at least one high school and at the Ohio Hi Point Joint Vocational School; (7) form a student support group and make counseling available; and (8) present workshops for teachers and parents and provide ongoing inservice training for teachers. In the Bellefontaine component, the program will (1) determine the prevalence of risk factors in the community, using a pre-post survey; (2) promote improved nutrition, a lifetime exercise program, and development of a lifestyle geared toward promoting wellness through eight weekly Project RENEW instructional sessions; (3) have 750 parents participate in Project RENEW; (4) develop specific contracts for each individual in Project RENEW setting measurable health objectives; and (5) conduct a postsurvey at the end of the project year. The Centers for Disease Control's common data items will be used to collect base-line data on students, instructors, and families. A pretest will be matched with the presurvey of each student to determine the effect of the presurvey on awareness, knowledge, and attitudes. Impact evaluation will be conducted by using posttests and a postsurvey mirroring the presurvey. The evaluation process will establish correlations between families, teachers, and students, and how each affects the optimal outcome capabilities of the program. An Ohio State University consultant will be used to ensure standardization of all survey and testing devices and of the education of all instructors.

OKLAHOMA

81P-0618
Health Education-Risk Reduction (HERR) Grant Project, Oklahoma.
Gunn, R.
Oklahoma State Department of Health, Health Education and Information Service, 1000 N.E. 10, P. O. Box 53551, Oklahoma City, OK 73152
Funding Source: Center for Health Promotion and Educa-

tion (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Oklahoma was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The program will contact State, voluntary, civic, and professional organizations which have health-related interests or services. Updated surveys will be mailed to these organizations in order to inventory existing HERR services. Surveys will be compiled and published in a directory, indexed by county and community. This directory will be available for distribution to the HERR network and general public. An interdisciplinary advisory committee will be organized from State agencies, local intervention projects, and organizations involved in risk reduction activities. The HERR program will also maintain communication by a newsletter, site visitation, and review of quarterly progress reports from local intervention projects. The University of Oklahoma will develop instruments and sampling methods to be used in the determination of the prevalence of chronic disease risk factors. The advisory committee, State agencies, and local civic, voluntary, and professional organizations will assist in the evaluation of these methods. HERR will distribute instruments and sampling methods to funded intervention activities. They will also provide consultation and data management services to funded projects that wish to implement the CDC-BHE Risk Appraisal Program. Collected risk factor data will be incorporated into chronic disease morbidity and mortality data. Collected risk factor data will be distributed to the local intervention projects. The HERR State program will evaluate the prevalence system's collection, documentation, and distribution of data. A consultant epidemiologist will assist the State epidemiologist and the HERR program to develop a data collection system for chronic disease mortality and morbidity. This will include the identification of chronic disease and risk factors by checking death certificates, birth certificates, hospital discharge summaries, screening data, physician's reports, the tumor registry, insurance carriers data, and data collected by intervention activities. A computerized data file will be established. The surveillance system will be evaluated by its ability to identify chronic disease and associated risk factors, collect data, determine chronic disease prevalence, maintain the data file, and make preliminary prevalence determinations available to health professionals, the general public, and the HERR network. Revised guidelines that define communities with an organized approach to risk reduction and priorities for funding will be distributed to local projects. Technical assistance will also include resource materials, lists of professionals with expertise in risk reduction, assistance in identifying local resources, and site visitation. Quarterly progress notes will be monitored. The State HERR will also provide financial assistance to the local projects' determination of risk factors. The State will evaluate its effectiveness by the number and quality of intervention activity proposals submitted in FY 1982 and the documented behavioral changes in selected target populations.

81P-0619
Cherokee Nation Youth Services Health Education-Risk Reduction Project for Minority Youth.
Cherokee Nation Youth Services, OK
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Cherokee Nation Youth Services project is designed to (1) provide weekly educational group sessions to all students at the Stilwell Academy; (2) provide two educational group sessions each week to children and youth 6 years old and above at the Cherokee Nation youth shelter in Stilwell; (3) provide individual counseling and family and educational group sessions to native American youth in Adair County who are arrested on alcohol charges; (4) determine the risk factors in Adair County by surveying at least 70 percent of all junior and senior high school students; and (5) form a coalition of all agencies that work with youth in Adair County to plan and implement a countywide service system to deal with alcohol and tobacco use among county youth and address means of preventing these problems. To accomplish these goals, respectively, (1) a project counselor will provide one educational group session per week to all academy students, and pre- and posttests will be administered and audiovisual materials will be utilized; (2) pre- and posttests will be administered and pamphlets, books, and posters will be utilized; (3) a system of referral worked out with judicial and law enforcement officials will be implemented; (4) a survey will be developed by individuals from youth services and cooperating agencies and administered in the schools; and (5) a formal coalition will be formed. To evaluate each goal, respectively, (1 and 2) results of pre- and posttests will be evaluated to measure changes in attitudes about or use of alcohol and tobacco; (3) recidivism rates will be contrasted; (4) 70 percent of students will be surveyed and results compiled, analyzed, and distributed; and (5) the number of agencies participating in the coalition will be assessed; the goal is for 70 percent of all possible participants to attend.

OREGON

81P-0620
Health Education-Risk Reduction (HERR) Grant Project, Oregon.
Klascius, A.
Oregon State Health Division, Maternal and Child Health Section, P. O. Box 231, Portland, OR 97207
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Oregon was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. A Risk Reduction Grant Task Force composed of 19 official and voluntary agencies, unions, universities, and media will be formed to advise the State HERR program on the identification of health services and projects to be inventoried, inventory collection procedures and techniques, updating, and dissemination of information. Special relationships will be established with the Oregon Department of Education, Mental Health Division, Teen Health Promotion Task Force, and State universities. A statewide newsletter will be distributed to local, voluntary, public, and private agencies and to organizations which are potentially interested in carrying out risk reduction efforts. Working relationships will be documented by site visits reports, Task Force minutes, and content of the newsletter. The Risk Reduction Grant Task Force will assist in determining risk factors in specific target populations. Communities identified as having unusual or high risk factors will be asked to cooperate in organizing and utilizing public and private resources for the specific target populations. The State Vital Statistics Section will provide assistance in identifying existing sources of chronic disease and risk factor data. The member agencies of the State Teen Health Force will define the nature and scope of health problems that can be prevented by intervention programs in specific segments of the population; they will also identify changes necessary to improve the surveillance of chronic disease and risk factors. Guidelines for local intervention projects will be developed during the year and will be promoted through a newsletter, local health departments, school districts, and health systems agencies. "Networking" will be stressed and local health departments, voluntary agencies, and school districts will be required to work together in order to gain State priority for funding of intervention projects.

PENNSYLVANIA

81P-0621
Health Education-Risk Reduction (HERR) Grant Project, Pennsylvania.
Schechter, C.
Pennsylvania Department of Health, Bureau of Community Services, P. O. Box 90, Harrisburg, PA 17120
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Pennsylvania was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The program will establish an ongoing statewide system which periodically collects and distributes information on the availability of HERR resources. Guidelines will be distributed with brief descriptions of inventory uses and methodologies. Local agencies, included in the 1980 directory of resources will be resurveyed. Use of the resource directory will be evaluated by sample survey. A revised and updated directory will be published and distributed. In order to maintain awareness of the status of the program and to identify cooperative strategies with other State agencies, the State HERR will continue to establish contact with agencies and health education coordinating groups. This contact will be made by telephone, personal meetings, group presentations, and distributions of fact sheets. The program will keep interested agencies informed of program accomplishments. The program will identify groups presently coordinating health education activities on a State-level and possibly utilize committees from these groups to perform specific task-related functions. New advisory and planning groups will be time limited and task specific and organized when an existing committee cannot be utilized. Cooperative agreements will be made with the State Departments of Education and Alcohol in order to seek advice on proposed activities and review of intervention

proposals. The HERR program will also meet with the State Interdepartmental Health Education Committees and the Interagency Prevention Council. To encourage the exchange of resources between State agencies, the program will also fund the implementation of the School Health Curriculum Project. The file on health education program planning and evaluation and the Office of Health Information and Promotion publication concerning risk factor assessment will be updated to include CDC-recommended survey methods. The HERR program will review the information and resources needed to conduct risk factor prevalence surveys. They will also assist the local intervention project in the selection of appropriate survey methodology. The State will coordinate and financially assist the initiation of a coding system for mortality data. In conjunction with other agencies, the State HERR will determine data needs and secure commitment of resources. A plan for statewide survey of the prevalence of risk factor and related conditions will be developed. Workshops and consultation regarding program planning, intervention strategies, and evaluation will be provided for the staffs of funded intervention projects, HSA's, and district health offices. The State program will utilize consultants in the State with expertise in planning and implementing intervention programs and consultants with expertise in health education planning and evaluation. A workshop will be convened so that the staff of the local intervention projects can share experience and information as they develop program objectives, select intervention strategies, and identify resources outside their local communities. Training and workshop sessions will also be conducted for the staff of the HSA's, district health offices, and the Appalachian Regional Commission in order to improve the capacity of the regional agencies to provide assistance in the design of HERR programs.

81P-0622
Community Health Intervention Project (CHIP).
Pennsylvania Department of Health, Office of the Deputy Secretary for Public Health, P.O. Box 90, Harrisburg, PA 17120
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The goal of the Community Health Intervention Project (CHIP) is to develop a community-based program that lowers the incidence of five risk factors--smoking, hypertension, diet, obesity, and exercise--associated with coronary heart disease and stroke. As much as possible, intervention activities will utilize existing networks such as industries and unions, informal and religious groups, health and human service agencies, educational institutions, the health care system, food chains, and pharmacies. The first phase of CHIP will consist of an information campaign to create community awareness and interest in the project. Next, practical activities will be initiated, and community resources will be mobilized. These first programs will include (1) a comprehensive community program on hypertension; (2) lifestyle workshops; (3) a comprehensive antismoking program; (4) health hazard appraisals offered through different mechanisms; (5) conferences for community leaders which expose them to intervention activities appropriate for employees, students, etc.; and (6) recommendations for environmental changes, such as no-smoking sections in restaurants and the promotion of low-cholesterol foods through dairies and supermarkets. The last phase of the project will involve the development of a permanent, communitywide program by systematically integrating subprograms, improving utilization of community resources, and introducing additional services. The program will be carried out in Lycoming County (population approximately 115,000), a largely rural area with one central city and a number of smaller towns. CHIP will be evaluated in three ways: outcome evaluation, implementation evaluation, and cost-effectiveness evaluation. Outcome evaluation will measure impact on morbidity and mortality. Implementation evaluation will measure project formation and its impact on community health resources. Cost-effectiveness evaluation will gauge the economic savings to Lycoming County resulting from reduced disease rates. These types of evaluation will include the monitoring of community activities, knowledge, attitudes, risk-related behaviors, and risk factor levels. The University of Pennsylvania will assist in project development, ensure that all programs developed have a sound scientific base, and ensure that the project is appropriately evaluated.

81P-0623
Health Education-Risk Reduction (HERR) Program.
Dauphin County Executive Committee on Drug and Alcohol Abuse, Harrisburg, PA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction (HERR) Program is designed to (1) develop school- and community-based health education-risk reduction programs to deal with the causes of abusive behaviors among the target groups (black and Hispanic youth and their parents in Harrisburg), thereby decreasing smoking, alcohol abuse, poor nutritional practices, and physical inactivity, and (2) establish a communitywide network of effective prevention activities. To accomplish these goals, the program will (1)

develop relevant health curricula in both the cognitive and affective domains, to include four 2-week units on tobacco, alcohol, and nutrition; (2) establish peer counseling programs in the schools, including a peer training module; (3) provide parent workshops that reinforce school activities; (4) offer community-based programming for black and Hispanic residents, and packages developed on alcoholism, smoking, nutrition, and exercise during the first program year; (5) offer neighborhood workshops in black communities, cosponsored by existing community organizations; and (6) offer prevention activities at a Spanish-speaking center for Hispanic residents, to include a translated duplication of the school-based peer counseling program and the community-based neighborhood workshops for parents and youth combined. Evaluation will be conducted through (1) school-based program evaluation, consisting of pre- and posttests of students, peer counselors, teachers and parents, and a peer counselor school survey; (2) community-based program evaluation, including small group feedback sessions, use of social indicators, and monitoring of public service agencies in the area; and (3) recordkeeping and monthly progress reports.

81P-0624
Minimizing Alcohol Problems and Smoking Among Youth.
University of Pittsburgh, School of Education, Rehabilitation Counseling Department, Pittsburgh, PA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Minimizing Alcohol Problems and Smoking Among Youth is designed to (1) achieve the following outcomes for adolescent participants: (a) increased knowledge about alcohol and tobacco and their effects; (b) reduction in the prevalence of substance use among treated adolescents; (c) delayed onset of use as compared with quasi-controls; (d) decreased consumption of alcohol or tobacco (quantity and frequency measures); (e) healthier patterns of use; (f) reduction in negative consequences associated with drinking; and (g) changes in attitudes towards substance use; (2) effect changes in knowledge, attitudes, and behavior among peer leaders as a result of participation in the project; (3) promote significant gains among teachers in knowledge and attitudes toward alcohol and smoking; (4) develop and disseminate risk reduction curricula for school and community programs, and evaluate their relative merit; and (5) compare levels of intervention for adolescents to determine the efficacy of short- versus long-term prevention programming. The program will be conducted through (1) recruitment and training of peer leaders from grades 10-11; (2) a semester-long elective course, meeting twice a week, for interested students in grades 6-7, to include peer videotape presentations and small group exercises using peer leaders to facilitate discussion, with the core being a tested alcohol education course; (3) a smoking and alcohol prevention course offered in an abridged 9-week form as part of the required junior high health education course, using high school peer co-leaders; (4) a 9-hour teacher training program; and (5) a health information center to disseminate information to students; to share resources with the community; to serve a liaison function with faculty, neighboring schools, and community agencies; and to sponsor alcohol, smoking, and health risk reduction activities. The evaluation will make use of a target and a control school. Participants in long and short courses and peer leaders in grades 10-11 will be surveyed. Course evaluations will be administered, and pre- and posttests will be given to teachers. Records and logs will be kept on health information center use. Variables such as sex and grade will be studied.

PUERTO RICO

81P-0625
Health Education-Risk Reduction (HERR) Grant Project (Educational Program for the Control of Chronic Diseases in Puerto Rico Through the Reduction of Risk Factors), Puerto Rico.
de Lameiro, A. A.
Puerto Rico Department of Health, Buiding A, Call Box 70184, San Juan, PR 00936
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Puerto Rico was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. An inventory will be made of existing agencies and organizations in Puerto Rico that develop educational activities and programs toward the reduction of risk factors affecting health. Close coordination will be developed between governmental, voluntary agencies, professional organizations, and organ-

ized community groups with a potential for the development of programs and activities related to the reduction of risk. In a pilot project at Malpico, Rio Grande, coordination will be established and maintained with 26 different State, private, and public organizations and agencies. Coordination will be achieved through individual interviews with these 26 groups, meetings for planning, information giving, and evaluation; establishment and membership in counseling boards; education activities for members of boards; treatment groups organized by member agencies; and participation of specialized personnel from these organizations in the educational program. In the pilot project at Malpico, a survey which included risk factor information has already been administered to a sample of 38 percent of the 6,034 inhabitants. After the results of this survey are processed, this information will serve as base-line data in Malpico. The experience here will be used in initiating planning and organization of activities to develop and provide for gathering data related to the prevalence of risk factors associated with chronic diseases throughout Puerto Rico. Planning and organization of activities in coordination with the Information System of the Department of Health will be initiated so that by the end of the 5-year project period, an adequate system will be developed for gathering morbidity and mortality data regarding chronic diseases and related risk factors. Administrative, fiscal, and planning procedures will be established. The pilot project in Malpico will be fully established by the end of the second year of the program so that by the end of the fifth year, additional risk reduction educational projects based on the Malpico Project will be established in each of the six health regions of Puerto Rico.

81P-0626
Health Education Project to Deter Smoking and Alcohol Abuse Among Puerto Rican Youth.
Department of Health, San Juan, PR
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education Project to Deter Smoking and Alcohol Abuse Among Puerto Rican Youth is designed to (1) deter smoking and alcohol abuse among 700 students in Trina Padilla de Sanz High School; (2) achieve a significant increase in knowledge about the risks of smoking and alcohol abuse among participants; (3) achieve a significant positive change as to self-awareness, attitudes, and decision making; and (4) achieve a significant positive change in the adoption of new behavior patterns associated with smoking and alcohol abuse. Phase 1 of the program will involve 15 hours of instruction on facts about smoking and alcohol use, lectures and group discussions, audiovisual aids, movies, and readings. Phase 2 will involve 30 hours on attitude change, self-awareness, and understanding, utilizing small group sessions and psychodynamic techniques. Phase 3 will involve 15 hours on changing behavior patterns, conducted through simulated situations, role playing, and group discussions. Evaluation will be based on the Centers for Disease Control's common data items. A random sample of 112 students in grades 11-12 will be conducted; student satisfaction will be measured; and pre- and posttests will measure consumption changes and knowledge.

RHODE ISLAND

81P-0627
Health Education-Risk Reduction (HERR) Grant Project, Rhode Island.
Donahue, F. A., Jr.
Rhode Island Department of Health, Center for Health Behavior, 75 Davis Street, Providence, RI 02908
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Rhode Island was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. All Rhode Island communities will be surveyed via a questionnaire to compile the inventory of risk assessment or risk reduction strategies. The survey will also cover health agencies, businesses, and other appropriate groups or organizations. Followup will ensure that questionnaires are received from 85 percent of HERR programs. Data from the survey will be incorporated into the existing Health Agency Guide, a compendium of about 900 health and health-related agencies in Rhode Island. The State plans to communicate HERR program goals to State agencies and departments and to local voluntary, public, and private agencies in the community; to serve on advisory boards of key risk reduction agencies and continue funding relationships with organizations like the Red Cross and the American Cancer Society; and to develop methods and

programs by working with community centers of expertise like Pawtucket Heart Health and Brown University. By January 1981 the State will collect and analyze base-line data on risk prevalence obtained through the 1980 Household Health Survey; use a "wellness" mobile van and other methods of risk appraisal to determine the prevalence of risk factors in specific populations such as high-risk occupational groups; determine the feasibility of additional surveys to complete the common data elements, identify pretested survey instruments, and subcontract for priority surveys; determine the feasibility of assessing risk prevalence among pregnant women; and provide technical assistance to intervention projects. A preliminary surveillance system is already operated by Rhode Island Health Services Research, Inc. (SEARCH). Project staff will continue to evaluate SEARCH's health data. Risk data for industry will be developed using an existing compilation of mortality and morbidity indices. The State will compile an inventory of all existing State agency data sources by December 1980. The State plans to continue to develop three community intervention programs (Community Smoking and Alcohol Project; Accident Prevention Program; Rhode Island's portion of the Four-State Second-Hand Smoke Campaign); evaluate current HERR programs so that better programs can be designed using 1980 data on risk factor prevalence; and continue to develop a wide variety of HERR programs throughout Rhode Island. The applicant will establish a central repository for innovative health curricula and methodologies by September 1981.

81P-0628
Rhode Island Accident Prevention Program.
Center for Health Behavior, Rhode Island Department of Health, RI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Rhode Island Accident Prevention Program is designed to (1) reduce the overall rate of preventable accidents in the State by at least 10 percent, to no more than 29 deaths per 100,000 by 1985; (2) reduce both the frequency and fatality of accidents by focusing upon known risk factors and agents which are associated with the greatest incidence of injury and death; and (3) alter the risk factors thought to contribute most to motor vehicle fatalities and serious injury. Three components will be implemented: (1) a medical and health community project to increase health care providers' knowledge of accidents as a major health problem, resulting in the integration of this information into the health education aspects of their practice; this phase will involve (a) several grand rounds conducted by the Brown University Department of Pediatrics, covering prevention of drownings, falls, burns, poisonings, and automobile and motorcycle accidents; (b) an inservice education program for health personnel who have frequent contact with preschoolers and their parents; (c) a continuing education program for injury prevention and control, centering on primary care physicians; (d) continuing education for nurses; and (e) a program for auto safety and the preschool child, coordinated with a hospital; (2) the school community project, which will involve packaged units of instruction; and (3) the community health education plan, which will provide a safety education and first aid program for the elderly; publish and circulate information on the antichoke maneuver; conduct a media campaign; develop a speakers bureau for accident prevention; and implement an outdoor advertising billboard campaign. The target group for the entire program will be the population of metropolitan Providence. A final evaluation will address the following questions: (1) did the program reduce the frequency and fatality of accidents in Rhode Island by 10 percent by September 1981? (2) were the program's activities implemented as planned? (3) how effective were the activities in achieving the program's goals? (4) for which groups was the program most successful? (5) for which groups was the program least successful? (6) how did social and political factors influence the program's development and impact? (7) what did the program cost? (8) how well was the project managed? and (9) what are the merits of the particular program, as compared with alternative programs?

81P-0629
Rhode Island's Community Smoking and Alcohol Project.
Rhode Island Department of Health, Center for Health Behavior, Providence, RI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Community Smoking and Alcohol Project is designed to (1) recruit and train teachers from four school systems in prevention curricula; (2) provide prevention and educational units and services for students in grades K-12, in four school systems, with testing before program implementation; (3) confront the smoking and drinking decision as a conscious decision, and equip young people with the knowledge and information required to make that decision; (4) initiate intervention (secondary prevention) and community support services to complement the primary prevention activities; (5) provide a comprehensive program of school health education, strengthening of parental roles, counseling and peer support activities, public

service announcements, better examples of health care providers, communitywide awareness programs, and preservation of the rights of nonsmokers in public places; and (6) assure continuity of direct services to students and school systems beyond the first year. To accomplish these goals, the program will (1) hire staff and establish an advisory and coordinating committee; (2) negotiate subcontracts with direct service vendors; (3) recruit and train teachers; (4) pretest students; (5) deliver each educational component; (6) implement a peer counseling and cross-age teaching project; (7) establish the community support components; and (8) posttest students. Each of the program's components will use at least one nationally validated program. An evaluator will review the findings associated with each validated program and propose outcome objectives appropriate to that program; help the Center for Health Behavior coordinator establish appropriate charts or review sheets to monitor the weekly progress of each contractor, to ensure the time for completion of all activities; monitor the evaluation efforts of each subcontractor to ensure an evaluation of each program; provide an interim report containing the evaluation plans for each program, a summary of evaluation efforts to date, and a summary of the project's accomplishments for the 6-month period; and provide a final report within 30 working days of the project's completion.

SOUTH CAROLINA

81P-0630
Health Education-Risk Reduction (HERR) Grant Project, South Carolina.
Merritt, P. W.
South Carolina Department of Health and Environmental Control, Division of Chronic Disease Control, 2600 Bull Street, Columbia, SC 29201
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in South Carolina was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The program will inventory programs and services for selected risk related topics. The State HERR project or Health Awareness Promotion Initiation (HAPI) will conduct needs assessment among voluntary health agencies, professional organizations, and education groups to determine priority concerns and problem areas. In cooperation with interested agencies and organizations, a HERR conference will be convened to address identified needs, and provide professional and public educational opportunities relevant to risk reduction. HAPI will actively support and cooperate with existing councils, groups, and communities which have the goal of reducing chronic disease. HAPI will cooperate with voluntary and professional organizations and agencies to disseminate brochures and catalogs listing health education resources. They will work with interested agencies to develop a mechanism for updating brochures and catalogs annually. In cooperation with the University of South Carolina, Department of Health Education, HAPI will identify industrial worksite occupational and safety health educational programs. They will develop and distribute brochures with information regarding computerized literature and services available to agencies and organizations involved in risk reduction. HAPI will also cooperate with the State health department's educational resource center to catalog, organize, and file audiovisual and print material relevant to risk reduction and develop bibliographies addressing selected risk-related topics. A telephone survey instrument to collect CDC Common Data Items statewide with random-digit-dialing sampling methodology will be developed. HAPI will tabulate, summarize, and distribute data to CDC, local intervention projects, health systems agencies, and others interested in risk factor prevalence data. HAPI will continue to retrieve data related to prevalence of selected risk factors from the Carolina Health Survey Data. A newly initiated coding system to analyze multiple causes of death will be used with a random sample of death certificates to determine the occurrence of risk factors. This coding system will also be used to identify the occurrence of risk factors from secondary diagnoses on hospital discharge records. On a random sample of discharges listing chronic diseases, HAPI will develop and conduct a follow-back study to determine the occurrence of risk factors. New sources of additional information relevant to morbidity and mortality of chronic disease and related risk factors will be examined from Blue Cross-Blue Shield. They will also study the possibility of establishing a system to collect data from rural and urban communities concerning visits to physicians for chronic disease and related risk factors. HAPI will test the effectiveness of three smoking cessation plans developed with project funds. They will also cooperate with the planning and implementation of HERR activities as evidenced by their work at health fairs, public and professional workshops, presentations, and exhibits. HAPi will develop one presentation on identifying re-

sources and developing health promotion. HAPI will provide assistance, consultation, and monitoring of local intervention projects.

81P-0631
Health of the School-Age Child--Community Implementation.
South Carolina Department of Health and Environmental Control, Division of Chronic Disease Contol, 2600 Bull Street, Columbia, SC 29201
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The "Health of the School-Age Child--Community Implementation" project has three major objectives: (1) 80 percent of teachers participating in the course in health systems agencies (HSA's) II and IV will demonstrate knowledge levels sufficient to achieve a score of 90 percent on a posttest of course content; (2) 80 percent of participating teachers will experience an increase in positive attitudes regarding health topic areas as measured by pre- and postcourse questionnaires; and (3) a report will be developed which identifies and details the role and responsibilities of a school health education coordinator. To accomplish these objectives, the project will (1) conduct a health education summer institute (consisting of a minimum of 45 contact hours for up to 45 teachers) using the "Health of the School-Age Child " curriculum, 4 videotaped presentations on methods and techniques for teaching health education, and pre- and postcourse tests; (2) conduct a literature search to identify roles and responsibilities of a school health education coordinator; (3) obtain and review job descriptions of school health education coordinators from other States; and (4) interview Beaufort school district staff and professional health educators concerning roles and responsibilities of school health education coordinators currently on staff. The target group consists of teachers in HSA's II and IV. Evaluation will involve pre- and postcourse tests administered to institute participants.

81P-0632
South Carolina Intervention Project for Childhood and Adolescent Obesity.
Department of Physical Education, College of Health, University of South Carolina, SC
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The South Carolina Intervention Project is designed to (1) establish a valid community-based intervention treatment model (prototype) for childhood and adolescent obesity, with the long-range goal (second project year) of replicating the program at selected model sites within diverse community locations; and (2) help participants achieve weight loss, changes in eating behavior, increased physical fitness levels, and more positive self-concepts and family environments. To accomplish these goals, the program will (1) refine and validate a multidisciplinary behavioral intervention model designed to combat the problem of childhood obesity; (2) survey children to determine physical, nutritional, and psychological variables; assign them to groups; and pretest them; (3) implement the program, consisting of physical activity sessions 2 days per week for 14-16 weeks; (4) hold meetings for parents and children once a week in both large group and counseling sessions at the schools for behavioral self-management training in regard to eating and nutrition; (5) administer a posttest; (6) give followup evaluations at 4-month and 1-year periods; (7) help local intervention teams organize model programs to be held during the second project year; and (8) collect data and compile results from the prototype (and the replications at the model sites in subsequent program phases). The target group will consist of low-income families with an obese child in Lexington School District No. 2. Obesity is best measured by the degree of adiposity; nutritional status relative to salt intake, saturated fat, simple sugars, and cholesterol can be assessed through a 24-hour dietary recall; changes in fitness levels, motor skills, and physical activity patterns can be adequately assessed through either laboratory techniques or field measures; changes in self-concept and family environment can be indicated through certain tests. Data will be analyzed according to the design of the study. A comparison will be made between the test and control groups on each of the evaluative measures separately. Data will probably be analyzed utilizing analysis of covariance with an alpha level of .05 acceptable for significance. If possible, the data will be analyzed through a multidimensional procedure.

81P-0633
Three Rivers Accident Prevention Project.
South Carolina Department of Health and Environmental Control, Division of Chronic Disease Control, Columbia, SC
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The objectives of the Three Rivers Accident Prevention Project are to (1) collect epidemiologic data related to

accidents, (2) reduce hospitalization due to accidental falls among the elderly by 10 percent, and (3) increase the use of infant and child restraints in automobiles by 20 percent. To accomplish these tasks, the project will (1) work with various agencies and organizations to develop or modify data systems that can provide a clearer definition of the problem; (2) provide a number of workshops for nursing home residents, inservice instruction to nursing home staffs, 10 workshops for various senior citizen organizations, 10 workshops on preventing accidental falls in the home, and 2 radio and 1 television public service announcements to promote public awareness of the importance of prevention of accidental falls; (3) conduct educational programs on the importance of infant and child safety restraints for maternity patients in all hospitals having prenatal programs, pediatricians and obstetricians, organizations that transport children, organizations composed of young parents (for example, elementary school PTA's), and elementary school teachers; and (4) encourage major retailers to promote infant and child safety restraints in baby gift registries and advertisements. The target group consists of residents within the Three Rivers health systems area, particularly the elderly and children up to 10 years of age. Process evaluation will be performed to determine whether stated objectives are met as planned. Outcome evaluation will involve the collection of epidemiologic data and will determine whether or not services provided contributed to a decrease in accidental falls among the elderly and an increase in the use of infant and child restraints.

SOUTH DAKOTA

81P-0634
Health Education-Risk Reduction (HERR) Grant Project, South Dakota.
Dvorak, J.
South Dakota Department of Health, Division of Communicable Disease-Laboratory, Joe Foss Building, Pierre, SD 57501
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in South Dakota was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. By November 1, 1980, the State will establish a register of its existing HERR activities which identify type of health education, which organizations present the education, and the recipients. By September 1, 1981, the State will update this register; identify public, private, and volunteer agencies currently involved or potentially capable of becoming involved in HERR services; establish a systematic method to record activities in which various agencies are involved; survey identified agencies and record HERR activities in which they are involved; establish a register system which will identify agencies involved in HERR and which records the activities; and build into this register a method to update it when new agencies involved in HERR are identified. By August 1, 1981, the State will survey information in this register; and work with CDC and HERR staff to develop a survey instrument to reflect knowledge about preventable health attitudes and awareness. Goals for FY 1981 include: by January 1, 1981, to establish a mailing list of voluntary health agencies, professional organizations, and educational groups; by February 1, 1981, mail these groups current information about the State and local HERR projects; identify State and local Boards of Education, school systems, PTA's, Cooperative Extension Services, etc.; develop a system for maintaining a mailing list of these various organizations; prepare a synopsis of current HERR activities at the State and local levels; provide these agencies a contact person to enable them to obtain more information about HERR and how they can become involved in their school or community; and complete and mail a letter to voluntary health agencies, professional organizations, and educational groups making them aware of current HERR information. By November 1, 1980, personnel will be available within the Chronic Disease Program to establish methods and procedures to collect risk factor prevalence data contingent upon specific guidelines from CDC. By August 15, 1980, an HERR coordinator will be hired and training provided by the Department of Health and CDC. The coordinator will work with CDC personnel to develop Common Data Items pertinent to South Dakota and recommended by CDC. The coordinator will establish liaison with telephone company to develop a system to utilize telephone survey techniques. The HERR coordinator will present to Director of Chronic Disease Program an outlined procedure to collect risk factor prevalence data for local communities by November 1, 1980. Division of Alcoholism, Division of Drugs, and Chronic Disease Program of the South Dakota Department of Health are jointly planning to contract for a statewide incidence-prevalence-attitude study, to determine attitudes of South Dakota residents in regard to drug, alcohol, and smoking use. The study will addition-

ally include questions regarding nutrition, exercise, and hypertension as these areas relate to health and well-being. The survey will include a random sampling of geographic locations, demographic data, and analysis. Analysis of the data will include, but not be limited to, the following: prevalence, incidence, availability and accessibility, and attitudes of population at risk. This study will be comprehensive; allow comparison of State, local, and national data; and establish a base line for evaluation and implementation of alcohol and drug use, abuse, or misuse and smoking reduction programs directed toward high risk populations in need of services. Objectives for FY 1981 include: to determine by September 30, 1981, which chronic diseases are prevalent and of significance to the health of South Dakotans; analyze existing chronic disease mortality data located in the South Dakota Department of Health, Center for Health Statistics; identify high risk populations for chronic diseases in South Dakota by geographic area and demographic factors according to mortality information available and compare analyzed local mortality chronic disease data with other sources of national chronic disease data; with assistance from CDC, prepare an instrument which can be used to survey agencies such as Indian Health Services, community health nursing, communicable disease, chronic disease, and health resources as a method to establish existence of chronic diseases in specific areas of the State; complete and present to Director of Chronic Disease Program by September 1, 1981, a statistically supported document identifying at least three chronic diseases prevalent and significant to population of the State; establish by October 30, 1980, an agreement with the Center for Health Statistics, State Department of Health, to acquire morbidity data through hospital discharge systems, Blue Cross-Blue Shield, Medicaid-Medicare, and other sources to tabulate and analyze morbidity incidences by geographic areas and by time; inform the Center for Health Statistics Director of the HERR project and provide financial assistance to the Center for Health Statistics to expand their capabilites to obtain morbidity data from the various agencies; and provide the Statistical Center specific information in accordance with guidelines from CDC on what morbidity data are needed from the various agencies. The HERR coordinator will work in cooperation with the Center for Health Statistics to prepare an agreement by October 30, 1980. Goals include having an HERR coordinator hired within the Chronic Disease Program, who will be responsible for assisting community organizations involved in HERR projects to recognize mutual interests and complementary efforts and will identify resources outside of the communities which have received HERR projects that can assist the community in their local efforts. The coordinator will be responsible for providing communities that have HERR projects with Common Data Items, recommended by CDC; enable them to develop methods to determine the prevalence of health risks within the community; and will update local intervention projects on current recommendations by CDC on objectives, work plans, and health education methods. A statewide workshop will be held prior to March 15, 1981, to stimulate intervention activity proposals. Agencies and organizations will be identified from the HERR register, and the workshop will be held with assistance from CDC-HERR staff. Quarterly progress reports from each intervention project will be received on or before the last day of December, March, June, and September.

TENNESSEE

81P-0635
Health Education-Risk Reduction (HERR) Grant Project, Tennessee.
Wallace, J.
Tennessee Department of Public Health, Division of Health Risk Reduction, TDPH State Office Building, Nashville, TN
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Tennessee was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The program will compile and distribute a directory of HERR activities in Tennessee. Quarterly meetings will be held for health officers, leaders in the health department, legislators, leaders from other agencies and organizations, and individuals in private industry on the subject of risk reduction. CDC's recommended Common Data Item questionnaire and suggested methodology will be adapted to suit program needs within the State. A joint effort with the Chronic Disease Division will be made to develop new methods of collecting chronic disease data, identify present methods of collecting risk factor data, and establish a method for collecting data from hospital admissions. Onsite visits will be made to assist with the technical and management aspects of data collection. Statistical expertise will be obtained to assist local programs. Establishment of the State

HERR program as lead agency in providing technical and management assistance will be accomplished by assistance to recognize mutual interests in communities, by assistance in identifying outside resources, and by guidance in writing specific measurable objectives. A resource center of visual and other health education aids will be established. The State HERR program will evaluate funded interventions by comparing local data to other similar programs and national data. A contract will be made with Middle Tennessee State University to provide technical assistance in evaluation to local intervention projects. Assistance to potential proposers of funding and onsite visitation will be provided in order to encourage and assist with the establishment of organized community efforts.

81P-0636
Health Risk Reduction Project for Carter, Johnson, and Unicoi Counties.
First Tennessee Regional Health Office, Johnson City, TN
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Risk Reduction Project is designed to (1) decrease the rates of risk behaviors and increase the development of informed decisions concerning personal lifestyles among adolescents in Johnson, Carter, and Unicoi Counties; (2) identify and evaluate existing resources and services aimed at teenage smoking and other health risk practices; (3) coordinate with local school systems, the American Lung Association, and other advisory agencies the planning and development of a comprehensive educational program to increase awareness and knowledge of health effects related to smoking and other health practices such as alcohol use; (4) establish and maintain a resource materials center; (5) implement a smoking education curriculum in grades 6-12 to reach approximately 8,000 students; (6) develop a smoking cessation program to reach 50 percent of the identified smokers in grades 10-12, approximately 400 students; (7) plan future smoking education and cessation programs for parents and teachers; and (8) develop ongoing curriculum and programs to address needs identified by evaluation and surveys. The program will be conducted through distribution and cataloging of resource materials, distribution of health surveys, telephone followup and contact, advisory committees, inservice training sessions, and a media campaign. For evaluation, (1) quarterly reports will be submitted to detail project areas of involvement; (2) results of student pre- and posttests will be used to determine levels of comprehension; (3) students will be asked to evaluate presentations for interest and content; (4) the initial survey will be repeated at the end of the project year to determine changes in smoking habits, attitudes, and knowledge.

81P-0637
Health Education-Risk Reduction Program to Reduce Smoking and Alcohol Use Among Adolescents.
Quinco Community Mental Health Center, Bolivar, TN
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Program is designed to (1) significantly reduce the incidence of alcohol and tobacco use among the 780 students in grades 7-9 in Bolivar (Tennessee) Junior High School by 20 percent by August 31, 1981; (2) increase community awareness of the risks of teenage smoking and drinking, and develop community support for intervention; (3) increase community involvement in the campaign to increase positive peer activities for teenagers; and (4) develop materials and curricula that will focus on increasing a positive body image, decreasing vulnerability to peer pressure, and increasing awareness of the importance of good nutrition and exercise. The school-based program will be provided on campus to ensure integration with existing school programs. Pre- and postquestionnaires will be used to assess the frequency and quantity of alcohol and tobacco use by students. Seventh graders will be provided with formal lectures, audiovisual presentations, and scientific experiments on smoking and alcohol at least one class period per week. Ninth graders will be involved in a communication course one class period per week, focusing on debates, rap sessions, role playing, and conflict resolution and values clarification exercises. All junior high students will be exposed to a physical education program designed to increase lung capacity, personal stamina, and muscular control. Two high school seniors (one male and one female, one black and one white) will serve as assistants for activities and as positive models. The project coordinator will be available at the school 1 day per week to serve as a consultant. One inservice staff member will be provided to acquaint teachers with project goals, and staff members and task force members will be trained. A 6-week Youth Awareness Group will be offered on a regular schedule, and two 2-week intensive summer camp sessions will also be offered. Evaluation will involve (1) a survey conducted at the beginning of the project, then readministered in the last month of the 1980-81 school year; (2) administration in the second year of the same survey to entering seventh graders in the fall and to the entire student body during the last month of the school year; and (3) administration of the survey at another junior high school, which will act as a control.

TEXAS

81P-0638
Health Education-Risk Reduction (HERR) Grant Project, Texas.
Harle, H. L.
Texas Department of Health, Chronic Disease Division, 1100 West 49th Street, Austin, TX 78756
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Texas was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. Data gathered in FY 1980 on existing HERR programs and activities will be reviewed and edited by the project coordinator. A catalog of HERR activities will be published by January 1981 and distributed to Health Systems Agencies in Texas and to the 12 regional offices in the Department of Health. Public health periodicals will be reviewed for new HERR programs that should be included in the catalog. The applicant will continue to communicate the goals and activities of the Texas LIFE Program (TLP) to other State agencies, which will be asked to advise, review, and participate in the TLP. For instance, the Texas Commission on Alcoholism will be asked to help counsel people with alcohol problems. The TLP coordinator will also keep abreast of other agencies' HERR activities and assist such activities as requested. At least one representative of the TLP will attend the quarterly meetings of the Texas Interagency Council on Smoking and Health. The TLP will use consultative services available from the Department of Health to determine the prevalence of risk factors related to chronic disease and will identify and involve organizations with appropriate expertise. Technical assistance will be provided to communities and organizations conducting local surveys on the prevalence of risk factors. Communities and organizations conducting local intervention programs will be asked to submit annual reports on risk factor prevalence in their areas. Chronic disease mortality data will be collected and reviewed by the applicant in cooperation with several other State agencies, such as the Bureau of State Health Planning and Resource Development and the Vital Statistics Division. Other public and private agencies like the University of Texas Medical School, Blue Cross-Blue Shield of Texas, and local health departments will be asked to provide morbidity and mortality data on chronic diseases. State, voluntary, and other agencies will be encouraged to plan HERR activities. Communities undertaking an organized approach to risk reduction will be identified through the statewide inventory. Projects receiving Federal funds for smoking and alcohol intervention among youth will be evaluated at least twice a year. Technical assistance and consultation on HERR activities will be provided to communities.

81P-0639
Educational Strategies for Risk Reduction in Teenage Alcohol and Tobacco Use.
Education Services Center, Region XIII, Austin, TX
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Educational Strategies for Risk Reduction program is designed to (1) plan and implement a model prevention program, "Learning How to Make Quality Decisions about Tobacco and Alcohol Use," in six elementary schools; (2) plan and implement an adapted version of the American Cancer Society Smoking Cessation Program for Teenagers; and (3) plan and implement a model alcohol abuse prevention program in at least three high schools in the Austin Independent School District. To accomplish these goals, the program will (1) train classroom teachers in utilization of classroom strategies and materials on decision making; (2) survey students in grades 4-6 to establish smoking and alcohol use prevalence; (3) offer the American Cancer Society program to high school students; (4) include nonsmoking students in a smoking prevention-intervention clinic to provide a climate of support for students who do not smoke, as well as for those attempting to stop; (5) form campus leadership teams, to include administrators, teachers, nurses, counselors, and students, which will develop strategies for the 1980-81 school year; (6) help the campus leadership teams conduct a student and staff survey to establish base-line data on prevalence of alcohol use among student and staff populations; and (7) hold a conference in which staff and students are informed of campus-level program efforts. The target group will consist of teachers in grades 4-6 in the Central Texas-Education Service Center, their students, and high school students 14-17 years old. Four types of evaluation will be used: context evaluation (planning decisions to determine objectives); input evaluation (structuring decisions to determine project designs); process evaluation (implementing decisions to control project operations); and product evaluation (recycling decisions to judge and react to attainments).

81P-0640
Fort Worth Prevention of Alcohol and Tobacco Use-Related Problems Among Middle School Students.
Fort Worth Independent School District, Fort Worth, TX
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Fort Worth Prevention program is designed to (1) inform the target population (5,000 students in grades 6-7 in the Fort Worth Independent School District) about risk factors related to tobacco and alcohol; (2) foster behavioral decisions that will positively affect health; (3) reduce risk factors, resulting in a decrease in premature death and disability; (4) expand the pilot alcohol peer education program to include tobacco information; and (5) train 20-40 middle school science and health teachers in the use of recently developed nontraditional health education materials, films, and classroom activities pertaining to alcohol and tobacco risk factors. To accomplish these goals, the program will (1) train 60-90 high school students as peer teachers (half about alcohol and half about smoking) and 20-40 middle school science and health teachers; (2) conduct 5-10 workshops or presentations for parents and community groups; (3) develop curriculum materials that address the risk factors related to chewing tobacco; (4) evaluate the effect of the peer teachers and specially trained classroom teachers on the approximately 4,000 students in their classes, compared with 1,000 students in regular classes; (5) evaluate the impact of the peer education program on the peer teachers; and (6) evaluate the program at the end of each semester. Both outcome and process evaluation will be used. Analysis of base-line and followup data will be subjected to multiple discriminate analysis, multivariate analysis of variance, and appropriate nonparametric analysis.

81P-0641
Progressive Youth Theatre: A Smoking and Alcohol Intervention Proposal.
Hope Development, Inc., Houston, TX
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Progressive Youth Theatre is designed to (1) increase knowledge and awareness of the health hazards of smoking and drinking; (2) discourage, reduce, or eliminate tobacco and alcohol use among target area youth (students from 8 senior and 11 junior high schools, with at least 10,000 youth viewing the productions in person, and another 40,000 viewing the productions via radio and television); (3) utilize drama to develop and implement school- and community-based educational programs to deter children and adolescents from tobacco and alcohol use; (4) provide minorities and inner-city youth a viable peer group program to reduce the risks of developing alcohol and cigarette smoking habits; (5) use theater as a creative and emotional outlet for youth while showing the positive health, social, and psychological aspects of not smoking; and (6) provide a mechanism to elicit discussion among youth as to their attitudes about smoking and drinking and their own use patterns. To accomplish these goals, the program will (1) recruit 50 target area youth to help develop and perform drama and other productions that discourage tobacco and alcohol consumption, providing them with intensive education about the health hazards of tobacco and alcohol consumption; (2) arrange performances in schools, community centers, and churches, on street corners, and through the local media; and (3) produce (a) four one-act plays on the health hazards of habitual smoking and drinking, using positive peer group pressure to discourage consumption; (b) two 15-minute puppet shows on the dangers of tobacco and alcohol use; (c) dance-drama productions to demonstrate the negative health effects of smoking and drinking; (d) mock student debates for junior and senior high school students; (e) writing contests on alcohol and smoking decision making for junior high school students; (f) videotape presentations of the Progressive Youth Theatre (PYT) productions for replay to select audiences; and (g) radio and television public service announcements utilizing inner-city youth. A general rap session will follow each performance, and the audience will be encouraged to discuss alcohol and tobacco use with PYT youth and resource persons. Evaluation methods will include use of client records, attitudinal surveys administered before and after each performance, and quarterly and annual reviews and reports of all program activities.

81P-0642
Smoking and Alcohol Intervention Using Creative Teaching Strategies in Elementary and Middle Schools.
Dallas Independent School District, TX
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Intervention program is designed to (1) expand an already successful peer education program within the health studies curriculum in the Dallas Independent School District; (2) introduce a new, creative smoking project entitled "Do You Mime If I Smoke"; (3) complement the decision-making approach to teaching health education already existing in the school district;

and (4) involve high school students in working with younger students. To accomplish these goals, the program will (1) hire staff and four curriculum writers; (2) revise the seventh grade alcohol peer education program to include current alcohol information and teaching strategies; (3) develop a peer education component for teachers so they may better prepare their classes for peer visits; (4) implement the new alcohol peer education program in 98 percent of seventh grade health education classes; (5) plan and implement a training program for high school peer educators; (6) revise and implement the smoking peer education program for the fifth grade; and (7) adapt and pilot test the "Do You Mime If I Smoke" program using mime troupes from the Creative Arts Magnet School and Middle School. The target group will consist of the general student population of the district, which is 49 percent black, 32 percent white, and 17 percent Hispanic, with 2 percent composed of other ethnic groups. For evaluation, a curriculum-related instrument to measure cognitive changes of participants will be developed. Alcohol and smoking knowledge inventories will be administered using a pre- and posttest format and control groups.

UTAH

81P-0643
Health Education-Risk Reduction (HERR) Grant Project, Utah.
Kreuter, M. W.
Utah State Department of Health, Division of Community Health Services, P. O. Box 2500, Salt Lake City, UT 84110
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Utah was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. Based on the results of a survey conducted in 1980, a registry of HERR programs and services will be developed and distributed to all agencies and organizations involved in such activities. Individuals, agencies, and organizations most likely to refer people to such programs will also be sent copies of the registry. Agencies and organizations listed in the registry will be surveyed again during the year to determine if any of their programs or services have changed. The applicant will continue to work closely with public, volunteer, and private agencies and groups. Some of the organizations already involved include school districts; universities; local, State, and Federal health agencies; and the Utah Lung, Cancer, and Heart Associations. By November 1, 1980, data on the prevalence of five risk factors related to cardiovascular disease will be published and sent to the health officer in each county. These data were gathered during 1980 via a telephone survey of adults, through a questionnaire administered to Utah's schoolchildren, and through health hazard appraisals of participants at a health fair. The applicant will provide technical assistance to local organizations that wish to measure the prevalence of risk factors in their communities. The applicant will finalize agreements with various State agencies that collect morbidity and mortality data. These data will be collected and analyzed yearly to indicate trends in the leading chronic diseases. A statewide needs assessment for risk reduction projects will determine which areas and groups in Utah would most benefit from a risk reduction program. The needs assessment will be available to all interested agencies and organizations in Utah. The Utah State Department of Health will provide information and consultation to all interested agencies and organizations to encourage the development of risk reduction projects. By the end of FY 1981, at least four programs will be established. The department will also continue its smoking education-risk reduction program, which is designed to prevent or delay the onset of smoking among sixth graders.

81P-0644
Four County Alcohol-Tobacco Health Education Risk Reduction Project.
Timpanogos Community Mental Health Centers, Provo, UT
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Four County Alcohol-Tobacco Health Education Risk Reduction Project is designed to (1) implement in the King County, Washington, schools, grades K-12, the "Here's Looking at You" alcohol education curriculum; (2) implement the Utah Department of Health's smoking education-risk reduction program for sixth grade students in the school districts within the four counties; and (3) demonstrate and document the interaction of public agencies during FY 1980-81. To accomplish these goals, (1) a group of 21 teachers will review the King County alcohol education program and the Utah Department of Health's smok-

ing reduction program and synthesize them into a comprehensive, compatible package; (2) 55 teachers in 2 counties will be trained the first year in the use of the newly developed curriculum; (3) trained teachers will teach a minimum of 15 activities to their students, and secondary teachers on the semester system will present the curriculum twice a year in health education classes; (4) both an experimental and a control group will be identified for research and program evaluation purposes; (5) a minority advisory council will be selected, to consist of at least one representative each from the Asian, Mexican American, and native American communities; (6) the council will review curriculum materials and evaluate them for possible cultural bias; and (7) community experts will be incorporated into the alcohol-tobacco workshop. Process, effectiveness, and impact evaluations will be performed. Effectiveness will be measured using pre- and postprogram instruments; impact will be measured by the incidence of tobacco use and the delayed age at which the use of experimentation with tobacco begins. Teachers will be surveyed for subjective measures of effectiveness.

81P-0645
Health Education-Risk Reduction Project for Families at Risk for Hypertension.
Community Health Services, Utah State Department of Health, UT
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Health Education-Risk Reduction Project for Families at Risk for Hypertension is designed to (1) measurably reduce the risk factors associated with hypertension, and thus contribute to a future decline in Utah in premature death and disability from major cardiovascular disease; (2) develop a teaching manual for all local health departments and other agencies involved in the detection of at-risk individuals and families; (3) increase knowledge of the nature of hypertension and related diseases; (4) motivate the 50 high-risk target families to develop or maintain positive health practices; and (5) develop skills in family members for instituting or maintaining healthy behavioral change on the basis of informed choice and diminished risks. To accomplish these goals, the program will (1) identify all community resources, present and planned, providing hypertension services; (2) incorporate participating agencies into the planning phase; (3) implement a standardized data collection format, which includes family history of high blood pressure and related disease, for use by all agencies; (4) provide a list of hypertension program services to all related agencies, and encourage referral for education, followup, and maintenance service; (5) prepare a written protocol for possible target families, and identify a minimum of 75 high risk families for possible intervention; (6) develop an instructional model geared to high risk families; (7) provide training to the staff, 6 of whom will assist with family education; (8) when a minimum of 50 families have been selected, collect baseline data on each family member; (9) collect data on family members throughout the project; (10) survey all participants annually for blood pressure, weight, retention of knowledge, and maintenance of attitude and behavior changes; (11) conduct a posttest by mail; and (12) develop and study statistical models to measure intervention impact. For evaluation, data on families will be collected by participating agencies and institutions. Effectiveness will be evaluated by the behavioral changes instituted and maintained by the families. Exact instruments to be used will be developed during the first program year.

81P-0646
Navajo Youth Alcohol Risk Reduction Project.
Utah Navajo Development Council, UT
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Navajo Youth Alcohol Risk Reduction Project is designed to (1) implement an experimental educational program using the tactic of peer influence to help prevent and reduce alcohol abuse and tobacco use; and (2) search for valid insights into distinguishing characteristics of Navajo youth who do and do not survive the risk of drinking-related trauma. To accomplish these goals, the program will (1) institute a school-based, peer-led educational process using 11th graders to teach 6th and 7th graders; (2) provide peer leaders with a 2-week workshop that provides substantive information and communication skills; (3) provide a workshop taught by a medicine man, a physician, a nurse, a health educator, and a Navajo layperson; (4) assign peer leaders to selected elementary and middle schools to serve as resource persons; (5) establish a clinical program, staffed by two health educators, preferably Navajo; (6) provide health education services to clinic patients, particularly high risk patients such as teenage expectant mothers; (7) serve as a health resource to high school students; and (8) attempt to reach the community through a mobile outreach health promotion program. The target group will consist of the Navajo population on reservations on the Utah Strip, with emphasis on students in grades 6-7 and 11 and patients of the Montezuma Creek and Montezuma Clinics, especially pregnant adolescents and victims of alcohol-related accidents. Since the first year of this program is a planning year, evaluation will be a process evaluation. Detailed base-line data on the prevalence of alcohol and tobacco use will be gathered.

81P-0647
Utah Smoking Education-Risk Reduction Program.
Utah State Department of Health, Bureau of Health Promotion and Risk Reduction, P.O. Box 2500, 150 West North Temple, Salt Lake City, UT 84110
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Utah Smoking Education and Risk Reduction Program was initiated to prevent or delay smoking onset among selected sixth graders by increasing their knowledge of the consequences of smoking, enhancing their decision-making skills, and increasing their ability to resist persuasion. The program plans to develop, implement, and evaluate a combination of smoking prevention strategies based on educational principles that prevent or delay the onset of smoking among schoolchildren. Preceding implementation of the program, a pilot study was conducted to investigate the relationship between students' loci of control and smoking onset. The pilot study involved inservice teacher training, implementation of smoking prevention strategies, and repeated measurement of locus of control. The program subjects consisted of 4,000 sixth-grade students and 140 sixth-grade teachers within 10 school districts in Utah. The evaluation design for both the pilot study and the subsequent full study consisted of multiple pre- and postprogram tests involving independent and dependent variables obtained from treatment and control groups. Evaluation of the full study will also involve cross-sectional and longitudinal followup of participating sixth-grade students.

VERMONT

81P-0648
Health Education-Risk Reduction (HERR) Grant Project, Vermont.
Raiser, A.
Vermont Department of Health, Medical Services Division, 115 Colchester Avenue, Burlington, VT 05401
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Vermont was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. A mail survey of existing local and State risk reduction services, planned and implemented by the Interagency Council on Health with assistance by the State program, will be completed by December 1980. The inventory will be collated; cross-referenced by county, age, and risk factors; and distributed to State and local providers or would-be providers of risk reduction programs. By April 1, 1981, the Vermont Health Department will use this inventory to establish and maintain a clearinghouse to provide information about current risk reduction programs (descriptions, materials, key organizations, and personnel) at the State and local level. The Interagency Council on Health will begin to periodically review and update the system in June 1981. Vermont will develop three intervention "model" programs to illustrate, demonstrate, and stimulate cooperative working relationships among private, public, and State agencies in planning and providing risk reduction educational programs to three different target populations. By March 1981 the Program Committee, organized by the State program during 1980 and comprised of program representatives from Vermont's national voluntary organizations (Lung, Diabetes, Heart, Cancer), the Health Department Hypertension Coordinator, Alcohol and Drug Abuse Division, and a Nutritionist, will implement a cooperative risk reduction educational program for woodworkers in an industrial setting. This program will demonstrate cooperative working relationships among voluntary health agencies, and, as this target group has been identified as a high-risk population in Vermont, it is a logical target group for cooperative educational intervention. During 1981 the development, refinement, and formative evaluation of the Vermont Department of Health's Employee Risk Reduction Program will be continued and expanded to other employees of the State. The purpose of the program is to determine the feasibility, acceptability, and potential effectiveness of a health promotion program in a public occupational setting and to promote healthier lifestyles among the Health Department and, eventually, State of Vermont employees. This program will stimulate working relationships among various State agencies. During 1981 the development of the SEAT (Seatbelts Eliminate Automobile Tragedies) Program will continue and be expanded. The Model Infant Restraint Program will be replicated in 14 other Vermont community hospitals, and a Toddler Car Seat Rental Program will be initiated. This "model" program will stimulate close, working relationships among two governmental agencies (Transportation and Health) and various local organizations in the communities selected for expansion. The Risk Reduction Data Committee, organized by the State program in 1980, will

develop a random digit dialing survey tool as well as a mail questionnaire tool so that by January 1, 1981, a scientifically sound method will be developed for determining the prevalence of risk factors in communities. The survey tools will be field-tested by trained interviewers in Lamoille County, the first Vermont community to undertake an organized approach to risk reduction. CDC's recommended Common Data Items will be computer programmed and risk-factor prevalence data stored on computer. The Data Committee will have solicited interagency needs for a chronic disease morbidity risk surveillance system, resources to be channelled into a surveillance system improvement, and commitments by agency heads supporting the improvement of the system. By the beginning of 1981, a statewide health status survey will be planned and implemented to facilitate the collection of missing prevalence data for the Vermont community (exercise, nutrition, and seatbelt utilization). By September 1981 data sets will be completed, tabulated, and processed so that the HERR Project will have facilitated the collection of missing prevalence data. During 1981 the HERR Project will stimulate the development of local community working groups to undertake an organized approach to risk reduction in their communities. A training program will be held for people from State and local health agencies and organizations. This training program will update the Vermont community regarding recent scientific developments and trends in health education; define current state-of-the-art in the risk areas of alcohol, smoking, nutrition, exercise, accidents (seatbelt use), and stress; and provide technical assistance to local communities so they will be able to write intervention proposals for HERR. The State program will establish criteria for review and acceptance of these local applications. Also during 1981 the Lamoille Area Health Council will undertake an organized approach to risk reduction in Lamoille County utilizing L. W. Green's "PRECEDE" model to plan the organized approach. Target groups will be identified, base-line risk data of target groups assessed, educational programs will be implemented and coordinated by the Executive Director of the Health Council, and formative evaluation techniques will be used. The Lamoille County intervention project will enable one local community to initiate a coordinated approach to risk reduction, and the project provides a test community in which many State-level program elements can be pretested and evaluated.

VIRGIN ISLANDS

81P-0649
Health Education-Risk Reduction (HERR) Grant Project, Virgin Islands.
Schneider, R. L.
Virgin Islands Department of Health, Bureau of Health Education, Box 7309 Charlotte Amalie, St. Thomas, VI 00801
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in the Virgin Islands was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. In order to develop and maintain the inventory, the following is planned: (1) by October 1, 1980, develop a listing of all agencies and organizations within the Virgin Islands using the directory of governmental services, telephone directory, listings of community, private and professional organizations, listings of schools and colleges, insurance groups, and unions; (2) by November 1, 1980, develop a survey instrument of HERR services which will elicit program information in the following categories: smoking, alcohol misuse, hypertension, obesity, stress, and other; the survey will elicit information pertaining to specific target groups, program type, cost, sources of data relating to chronic disease morbidity and mortality and risk factor prevalence, interest in interagency participation, and number of participants; (3) by December 15, 1980, the survey will be sent to 10 preselected agencies on three islands and the survey will be evaluated for readability, understanding, brevity, and completeness; (4) by January 15, 1981, changes will be made in the survey according to results of the survey evaluation; (5) by March 15, 1981, the survey will be printed, packaged, and mailed with information on the State program, how the data will be used, and an indication that the agency will receive feedback of the survey information; (6) by April 25, 1981, all agencies with outstanding survey forms or incomplete survey forms will be contacted; (7) by June 1, 1981, survey information will be collated into a directory of risk reduction services; (8) by August 1, 1981, the directory will be printed and distributed to all agencies and organizations; and (9) by August 30, 1981, a condensed version of the

directory will be prepared and distributed. To develop and maintain working relationships with State, public, and private agencies with interest or services related to risk reduction, the following efforts will take place: (1) by October 10, 1980, send a letter containing information on the Virgin Islands HERR program to all agencies, and invite all agencies to a meeting to discuss information on risk philosophy, incidence of risks in the Virgin Islands, projected program plans, mutual interests, etc.; (2) by October 15, 1980, notify the general public concerning meetings to discuss risk programs; (3) by October 30, 1980, hold meetings on each island to plan and set objectives for improving risk reduction services; (4) by November 5, 1980, call agencies who do not attend meetings and update them on what occurred and invite them to the next meeting; and (5) by December 15, 1980, hold second meeting and begin to initiate stated objectives. To develop methods to determine prevalence of risk factors among selected target populations, the following is planned: (1) by October 30, 1980, hold meetings on each island for all agencies identified in the inventory to discuss methods to determine the prevalence of risk factors; (2) by November 15, 1980, develop an instrument to determine the prevalence of risk factors incorporating CDC's recommended Common Data Items; (3) by December 15, 1980, evaluate instrument by sending it to 10 agencies and the Commissioner of Health for comments and corrections; (4) by January 15, 1981, acquire the sanctions, endorsement, and clearances necessary to survey the population to determine the prevalence of risk factors; (5) by February 1, 1981, develop workplans to determine how, when, where, and by whom the risk assessment will be undertaken; (6) by July 1, 1981, complete surveys of three target groups; (7) by August 15, 1981, provide feedbacks to population surveys; and (8) by September 15, 1981, hold town meetings to discuss the results of the survey. In FY 1981 an inventory of existing data sources relating to chronic disease morbidity and mortality and the prevalence of risk factors will occur for the purpose of improving surveillance. Then by November 1, 1981, information relating to data sources of chronic disease morbidity and mortality and the prevalence of risk factors can be included in the survey of HERR services; and by January 1, 1982, a risk reduction surveillance system which includes cause of death related to risk factors, diseases caused, associated or contributed to risk factors, data obtained from hospitals, physicians, clinics, and mass screenings can be developed. In order to assist communities in OARR, the following is planned: (1) by October 30, 1980, develop local objectives and workplans in risk reduction with community organizations; (2) by February 1, 1981, develop a territorial plan to determine the prevalence of risk factors in the community; (3) by April 15, 1981, inform local agencies concerning the availability of Federal funding for intervention activities; (4) by May 30, 1981, provide technical assistance and consultation to agencies which plan to submit proposals for intervention activities; and (5) by August 1, 1981, identify resources within the community which may assist efforts in risk reduction.

VIRGINIA

81P-0650
Health Education-Risk Reduction (HERR) Grant Project, Virginia.
Werner, R. T.
Virginia State Health Department, Bureau of Health Education and Information, 109 Governor Street, Richmond, VA 23219
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Virginia was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. In FY 1981 Information and Referral Regional Centers are being established under a separate funding source. Each center will be asked to expand its computerized data collection instrument to include HERR programs. The computer printouts will be assembled into directory format for printing and distribution to interested agencies by September 1981. Special surveys will be made of worksite health promotion and risk reduction programs in the Central Virginia HSA service area and of patient education programs statewide for three high risk target groups (to be selected). The patient education survey will be done in conjunction with the Patient and Family Education Subcommittee of the statewide Health Education Advisory Committee. In FY 1981 the Technical Advisory Committee will be formalized and will begin functioning to provide expertise in methodology to assess risk factor prevalence and to provide specific intervention assistance to communities. Program inventory data will be used to identify agencies to form into local networks for assistance at the community level. An HERR Project Newsletter will be developed for State and local agencies. Special assistance will be given to the Richmond area to define community capabilities for utilizing cable

television to deliver health education, to identify patient education needs, and to identify sources of audiovisual materials. New liaisons will be established between the State-level program and both the Department of Mental Health and Mental Retardation and the Department of Education. In FY 1981 the State-level program coordinator will work with local and State groups to determine data collection needs and resources. One project health educator will compile all data into a workbook and training course on survey methodology to be provided to all communities interested in the HERR program. The health educator will also assist in analysis and use of the data collected at each site. In FY 1981 a Chronic Disease Data Surveillance Committee will be formed consisting of representatives from the Virginia Hospital Association, State Health Department Bureaus of Chronic Disease and Vital Statistics, university and medical college faculty, and communities undertaking an organized approach to risk reduction. With committee assistance, HERR program staff will identify specific data needs and data available and will recommend a protocol for aggregating existing data. In conjunction with the Hospital Association, implementation of a statewide hospital discharge data system will begin. Community-level workshops will be planned to share information on data sources and ways to utilize data. In FY 1981 efforts will continue with Safeway Stores to consider supermarket sites for nutrition education. This may lead to an intervention activity being implemented without Federal support. In FY 1981 two additional communities will be identified for intensive technical assistance in resource identification and proposal development. Workshops on the HERR program will be held for agencies identified in the two communities. A Health Risk Appraisal program for adults will be offered to selected communities in the State. An HERR resource center will be established in the State Health Department. Between 5 and 20 audio tapes will be developed for the 800 Health Line at the Medical College of Virginia. A special training manual for communities on use of the CDC Common Data Items will also be developed. Monitoring of funded intervention activities will require staff time and coordination with universities contacted to provide technical assistance in evaluation. In addition, one workshop will be held in each HSA area on techniques of grant writing and preparation for HERR proposals for 1982 funding.

81P-0651
Organized Community Approach to Reduce Risks of Adolescent Alcohol Abuse and Smoking in a Small Town and Rural Setting.
Region 10 Community Services Board, Charlottesville, VA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Organized Community Approach is designed to (1) implement CASPAR (Cambridge and Somerville Program for Alcohol Rehabilitation) and a smoking education curriculum in the public schools of Planning District 10; (2) organize community alcohol and smoking education advisory committees in each jurisdiction to determine the needs of that jurisdiction; (3) serve as a point of contact and referral for students with personal or family alcohol or smoking problems; and (4) organize and execute, in conjunction with the Interagency Council to Prevent Mental Retardation and Birth Defects, an ongoing public information campaign aimed at 9- to 18-year-olds concerning the risk of smoking or alcohol abuse. The program will utilize organized town meetings and meetings of the parent-teacher organization, workshops, classroom presentations, guest speakers, and media. The target group will consist of all persons in Charlottesville and the surrounding counties of Albemarle, Fluvanna, Greene, Louisa, and Nelson. The Region 10 Community Services Board will use the University of Virginia's Evaluation Research Center to design and monitor the activities related to project implementation. Evaluation will also be geared to assessing the project's impact, and the administration and coordination of cooperating services.

81P-0652
Smoking and Alcohol Abuse Prevention Project, School Health Curriculum (SHC).
Richmond Public Schools, VA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Abuse Prevention Project is designed to (1) revise and amend the School Health Curriculum (SHC) for grades 4-6 to increase its effectiveness in reducing risks of smoking and alcohol abuse among Richmond public school youth; (2) change those attitudes that influence intent to smoke or use alcohol by emphasizing decision skills, parent-family reinforcement, and peer reinforcement; (3) upgrade preservice training, inservice training, staff development, and teacher support and feedback; and (4) identify any problems unique to implementing smoking and alcohol education programs in the Richmond setting and with a target group of inner-city black youth. To accomplish these goals, the program will (1) train teachers, school nurses, and administrators in the use of the SHC, including the revisions; (3) begin teaching the SHC to fifth and sixth graders; (4) compare scores on a pretest and the scores of a control group with posttest scores to measure the project's impact; and (5) expand the program annually. The target group will consist of students in the Richmond public schools, 80 percent of whom are

black and 30.8 percent of whose families have incomes below poverty level. In the first year, 65 percent of all fifth graders and 3 percent of all sixth graders will participate; in the second year, all fifth graders, more sixth graders, and some fourth graders will participate; and in the third year, all fourth, fifth, and sixth graders will participate. Evaluation will be linked with phase II, components one and two, of the national evaluation of the SHC. The National Evaluation Committee will help identify a person to evaluate the program. Evaluation design and instruments for assessing program processes, impacts, and outcome will be developed and tested in conjunction with the Evaluation Committee of the National Center for Health Education. The Richmond public schools will carry out an evaluation with pre- and posttesting, longitudinal follow-up, and collection of common data items.

81P-0653
Smoking and Alcohol Intervention Program.
Virginia State Dept. of Health, Bureau of Health Education, VA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Intervention Program is designed to (1) provide users with information for responsible decisions regarding alcohol and tobacco; (2) reduce consumption of these agents among users; (3) provide services through existing county centers to individuals from families troubled by alcohol abuse; (4) reduce smoking behavior in 50 percent of pregnant women who smoke; (5) reduce alcohol intake in 75 percent of pregnant women who drink excessively; and (6) develop support from 50 businesses and professional and voluntary organizations to obtain 10,000 signatures on personal support pledges. The program will be conducted through (1) training of peer counselors: (a) six teachers or administrators will be trained in alcohol and tobacco information to provide support for peer counselors; (b) students will be selected as peer counselors and receive fifteen 1-hour sessions for 3 consecutive weeks on basic alcohol and tobacco information, self-awareness and values clarification, and basic communication skills; and (c) peer counselors will participate in a "rap room"; (2) professional training and services: (a) high school teachers, recreational personnel, and nurses will receive training in basic alcohol and tobacco information, and (b) professionals will be trained in awareness and understanding of the school peer counseling program, community resources, cessation programs, and the major purpose of the project; and (3) special projects, such as smoking cessation activities, procurement of community pledges of support for antismoking and alcohol campaigns, parent-youth discussion groups, cable television broadcasting of appropriate smoking and alcohol information, and determination of prevalence and consumption patterns. The target group will consist of elementary, junior, and senior high school students; parents; professionals who work with youth; potential users and abusers of tobacco and alcohol; users and abusers of these agents; and individuals whose families may be experiencing complications of alcohol abuse. An internal evaluation will review goals and objectives, activities accomplished, budget expenses, and staff recommendations; assess data collected; develop a final report; develop methodology for distribution to appropriate agencies; and develop suggestions for future plans and a possible evaluation model. An external evaluation will review the previous year's reports from juvenile court on alcohol-related offenses, review the previous year's State of Virginia traffic department report to Arlington Public Schools on youth traffic offenses for alcohol-related violations, assess information provided by courts and other sources, review and assess year-end data to determine changes in juvenile alcohol-related offenses, review and assess school records on incidents regarding driving while intoxicated, and review and assess other materials regarding lessening of alcohol and tobacco consumption among target populations.

81P-0654
Smoking and Alcohol Prevention Strategies (SAPS).
Virginia State Department of Health, Bureau of Health Education, VA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Prevention Strategies (SAPS) program is designed to (1) increase knowledge about smoking and health by 15 percent among the 1,740 fifth grade students in Norfolk public schools; (2) increase positive attitudes towards decisions not to smoke by 10 percent among fifth graders; (3) increase knowledge about alcohol and health by 15 percent among the 1,640 sixth graders; (4) increase positive attitudes towards decisions not to abuse alcohol by 10 percent among sixth graders; (5) reduce the number of cigarette smokers by 10 percent among fifth graders by June 1981; and (6) reduce the incidence of alcohol use by 10 percent among sixth graders by June 1981. The program will be conducted through (1) 2 health instructors selected by the cooperating agencies; (2) attitudinal and behavioral pretests among the target groups; (3) 10 lessons on smoking and health for fifth graders; (4) 10 lessons on alcohol and health for sixth graders; (5) selection of classes for experimental and con-

trol groups; and (6) lessons taught every other day, requiring 123 days. For evaluation, (1) evidence will be supplied of the degree to which program activities have been conducted according to schedule and plan; (2) pretests will determine knowledge and attitudes of students in experimental and control groups; (3) a second instrument will be developed to determine incidence of smoking and alcohol consumption among experimental and comparison groups before the program begins; (4) a posttest will be administered at the conclusion of the 10 lessons and at periodic intervals for the next 5 years.

81P-0655
Smoking and Alcohol Risk Reduction Program for Adolescents.
Virginia State Health Department, Health Education and Information, VA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Smoking and Alcohol Risk Reduction Program for Adolescents is designed to (1) implement a youth smoking cessation clinic; (2) help students become aware of choices regarding cigarette smoking and their health; (3) teach decision-making skills; (4) develop coping skills to help students maintain their health behavior decisions; (5) make students aware that people determine their own health habits; (6) help students expand their awareness of self, regardless of their pre- and postclinic smoking behavior; (7) train 3 health teachers to implement and coordinate peer facilitation programs in 10 schools; (8) train 100 peer facilitators in 10 schools; and (9) offer education programs concerning smoking and alcohol use to students and teachers in 10 schools. To accomplish these goals, the program will (1) assess the prevalence of risk factors through a questionnaire; (2) train facilitators; (3) obtain facilities and materials, e.g., a place for students to congregate, posters, bulletin boards, and projectors; (4) recruit participants (12-20 per clinic); (5) hold 9-week youth smoking cessation clinics (one session per week); (6) conduct four cycles of training for peer facilitators of the educational program; and (7) implement the educational programs for faculty, students, and parents, led by group facilitators. The target group will consist of students in grades 9-12 in 1 Richmond City public high school and 1 nonpublic high school between October 1980 and January 1981; by January 1981, 2 additional Richmond City public high schools and 6 additional nonpublic high schools will be included, for a total of 12,216. An evaluation tool to measure changes in behavior, attitudes, and knowledge will be developed. Quantitative evaluation of program performance will be based on demographic data on participants in the peer facilitation program; qualitative evaluation will be based on goal attainment scaling. Peer facilitators will, at the beginning of the program, identify measurable goals which they plan to reach during the 8-week peer facilitation training program, and the qualitative success of the program will be based upon participants meeting those goals. Once an individual has been through the peer facilitation program, continued quantitative and qualitative measures will be used by the individual peer facilitators.

WASHINGTON

81P-0656
Health Education-Risk Reduction (HERR) Grant Project, Washington.
App, H. F.
Health Education, Office of Community Health Services, Health Services Division, Department of Social and Health Services, Building LP I2C, Olympia, WA 98504
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Washington was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. The State will publish and distribute results of its inventory that has been made through the help of regional HSA's and State voluntary agencies. Prior to July 31, 1981, an update of this inventory will be completed. Appropriate agencies will be surveyed, and data will be computerized and stored. The State plans to develop and maintain working relationships with other agencies and organizations. State relationships with the Education Department and Alcohol and Substance Abuse are functional. The State-level program will facilitate collaborative working relationships by modeling important components for other organizations by: consistently and reliably furnishing information as well as accepting information which is offered; providing and sharing resources; developing and utilizing procedures for shared goalsetting and decision making; and reliably documenting goals that have been met. The State will establish

methods to determine prevalence of risk factors in communities and selected target populations. During the year, the State will schedule and conduct at least four seminars for interested local agencies to provide technical assistance on planning and conducting risk factor prevalence surveys. Written guidelines will be developed to assist communities in conducting both existing and future risk factor prevalence surveys. The State's goal is to identify existing data sources relating to chronic disease morbidity and mortality and to assist in improving surveillance systems Health hazard appraisal will be researched and evaluated as a method of assessing morbidity and risk factors. During January 1981 community populations of at least 50,000 will be surveyed to determine existing or potential surveillance systems in Washington State. During March 1981 a Task Force will convene to evaluate surveillance systems in terms of validity of procedures; comprehensiveness; sex, ethnic, other demographic characteristics; and accessibility to appropriate agencies. The State will stimulate and assist communities undertaking an organized approach to risk reduction. These activities will include eight regional seminars for communities during October 1980 and April 1981, two grant-writing seminars during January and June 1981, stimulation of future intervention proposals, and provision of assistance and consultation.

81P-0657
Mi-teem-ma, Indian-Alaskan Native Youth Demonstration Health Education-Risk Reduction Project.
Seattle Indian Health Board, Seattle, WA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Mi-teem-ma is designed to (1) provide alcohol education, prevention, intervention, and rehabilitation services to Indian and Alaskan Native youth; and (2) develop, design, and produce culturally relevant alcohol education materials, including posters, buttons, brochures, and audiovisual materials. To accomplish these goals, (1) the project coordinator will recruit the target population (30 native American 12- to 18-year-olds in the Seattle-King County area) by means of public service announcements, program brochures, posters, and flyers, and through referrals by departments of the Seattle Indian Health Board and other agencies; (2) the coordinator will plan and conduct health education-risk reduction classes focusing on the physical and psychological properties of alcohol and tobacco and their impact on health; (3) a questionnaire will be developed to measure the participants' knowledge and use of alcohol and tobacco; (4) a wide range of materials will be used to develop an educational multimedia component; (5) volunteers will be recruited and trained in leadership skills and risk management techniques; and (6) "talking circle" groups will be formed to provide a forum for the exchange of ideas and feelings regarding alcohol and tobacco use. For evaluation, a multiple-choice questionnaire will be administered by the end of the first quarter to measure the participants' knowledge and use of alcohol and tobacco. Posttests administered at the end of the second and fourth quarters will measure the impact of services. Additional evaluation measures include a quarterly evaluation of the number of participants enrolled, a random sample of individual participants to solicit responses to project activities, and an annual evaluation of the development and dissemination of media materials. If funding permits, future project evaluation will be contracted to a third party.

81P-0658
Program for Health Education and Risk Reduction in the Use of Alcohol and Cigarettes, Grades K-12.
Community Health Education Consortium, Spokane, WA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Program for Health Education and Risk Reduction is designed to (1) help ensure the optimal level of wellness possible for residents of the Inland Empire; (2) reduce alcohol misuse and eliminate cigarette smoking among students in grades K-12 in 50 out of 116 Spokane County schools; and (3) use television to produce effective, comprehensive health education programs, reaching much of the Inland Empire. To accomplish these goals, the program will (1) use the "Here's Looking at You" alcohol education curriculum and establish a central coordinating office and a program advisory council; (2) carry out a consistent, standard survey system to determine prevalence of risk associated with alcohol and smoking; (3) secure participation in a parents' evening by at least one-third of the parents of students to whom the curriculum is being taught; (4) produce a written document with other major Inland Empire health consortiums or groups that defines a mechanism for planning and implementing health education via television; and (5) correlate evidence of alcohol and smoking history of hospital patients with mortality data. For evaluation, pre- and posttest materials will be provided for teachers to administer in schools to measure perception of harm relative to use of cigarettes and alcohol. The Centers for Disease Control's common data items will provide base-line data for community and students. A survey will also be used to determine the percentage of people who are aware of the health programs on cable television.

81P-0659
Project Health: An Organized Approach to Risk Reduction.
Drug Abuse Council of Snohomish County, WA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Project Health is designed to (1) help the target group (students in grades 7-9 in Snohomish County) achieve attitude and behavior patterns that are health oriented and long lasting; (2) improve smoking, drinking, nutrition, and exercise patterns; (3) develop, test, and refine a short-term program that is cost effective, accepted by the community, and replicable in other settings; and (4) monitor the prevalence of risk factors throughout the county to establish base-line data to enable monitoring of changes over time. To accomplish these goals, the program will (1) form an advisory committee of social service agencies and schools and institute monthly meetings; (2) begin a workshop series in month 3, each series consisting of 8 sessions, 1.5-2 hours long, with an average of 10 participants, and covering (a) a pretest, an explanation of the program, and an introduction of facilitator and participants; (b) attitude exploration and recordkeeping of drinking behavior; (c) distribution of "Alcohol Facts" and polling of 25 people on 1 popular belief; (d) reporting of poll results and role playing of drinking situations; (e) discussion of nonsmokers' rights; (f) nutrition and exercise; and (g) filming a television program and completing a posttest; and (3) carry out a prevalence survey of county risk factors using expanded Centers for Disease Control common data items. For evaluation, (1) an individual evaluation instrument will be designed; (2) participants will give verbal and written feedback about the program; (3) each group of adolescents will be given a pretest, posttest, and followup posttests 2, 6, 12, 18, 24, and 36 months following workshop completion; and (4) an ongoing process evaluation will be conducted.

81P-0660
Risk Reduction Adolescent Program.
Twin Harbors Health Consortium, WA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Risk Reduction Adolescent Program is designed to (1) determine the prevalence and incidence of alcohol and tobacco use in grades 6-12; (2) provide skills and knowledge enabling pregnant teenagers to quit tobacco or drug use; (3) provide skills and knowledge that will enable teens taking birth control pills to quit smoking; and (4) develop teen-oriented mass media information and referral, and smoking cessation clinics. The program will be conducted through (1) a survey of 1,000 teenagers to identify incidence and prevalence of alcohol and tobacco use; (2) workshops for 180 pregnant teens emphasizing effects of smoking on the fetus and newborn and skills for stopping smoking; (3) identification and contacting of 220 teens who smoke and use oral contraceptives, and classes for smoking cessation; and (4) information and referral to approximately 2,500 Grays Harbor teenagers about the dangers of tobacco use. The target group will consist of 4,100 adolescents in Grays Harbor and Pacific Counties. For evaluation, records will be kept of the total number of surveys completed. Referrals from all agencies will be received by the project manager. An instrument for determining the need for further education or counseling will be developed. By February 1981, clinical workers will be tested and evaluated on knowledge and process skills, and a random sample of teenagers will be surveyed to determine if 25 percent are aware of smoking cessation resources.

81P-0661
Sumner Tobacco and Alcohol Risk Reduction (STARR) Project.
Educational Service District 121, Seattle, WA
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Sumner Tobacco and Alcohol Risk Reduction Project is designed to (1) reduce problems associated with alcohol and smoking among youth in the Sumner community by helping them make responsible decisions; (2) reduce consequences associated with the use of tobacco and alcohol in the Sumner community by intervening early with youth who are using or affected by the use of these substances; and (3) reduce problems associated with smoking and alcohol in the community by reducing the supply and desirability of both substances among the youth population. The program will be conducted through (1) use of the "Here's Looking at You" alcohol education curriculum; (2) use of two new modules to be implemented with the alcohol curriculum, one on fetal alcohol syndrome and the other on drinking and driving; (3) teacher training through 3-day inservice workshops; (4) parent education to acquaint parents with resources and training programs; (5) community speakers; (6) peer counseling; (7) adult role models to talk to students during class; (8) distribution of a program newsletter every 3 months; (9) review and revision of the school policy on smoking and alcohol use; (10) use of a drug education curriculum, entitled "If Drugs Are the Answer, Who Knows the Ques-

tions?" developed on lines similar to the alcohol curriculum; (11) biannual training of alcohol and cigarette vendors; (12) establishment of an information and referral center in the junior and senior high schools; (13) a media campaign and implementation of special police patrols; and (14) coordination of community groups to provide activities for youth. The target group will consist of the 4,457 students in grades K-12 within Sumner School District No. 320. Evaluation will be conducted by the project staff and by an independent contractor. Components to be evaluated include base-line data on health behaviors, effectiveness of various program elements, and knowledge and attitude skill changes. Methods to be employed include health behavior questionnaires, student interviews, archival and ethnographic data, pre- and posttests to measure teacher gains associated with training, and feedback forms included with each program activity.

WEST VIRGINIA

81P-0662
Health Education-Risk Reduction (HERR) Grant Project, West Virginia.
Haddy, L. E.
State of West Virginia, Department of Health, 1800 Washington Street, East, Charleston, WV 25305
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in West Virginia was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. During FY 1981 the West Virginia HERR program will establish the inventory in two or more selected communities. Both a rural and an urban community will be selected from a list provided by the State Advisory Committee. The inventory will be completed in the following manner: the State Advisory Committee members will provide a contact organization in each of the communities to be inventoried; the program will obtain information on HERR projects in the two selected communities using the assistance of the contact organization; and the program will publish an inventory of existing HERR programs for the two communities. The program will establish working relationships with agencies and organizations as evidenced by two or more of the following activities: providing technical assistance to communities demonstrating an organized approach to risk reduction; monitoring intervention projects; providing technical assistance in determining the prevalence of risk factors; providing assistance in promoting model standards for community preventive health services; and providing assistance in funding alternatives. Additionally, the State Advisory Committee will hold one meeting to inform interested agencies of the HERR program's goals, objectives, and activities. A working relationship with State and local agencies will be further evidenced by accomplishing activities with the following agencies: Lung Association, Department of Education, WV University, Heart Association, American Cancer Society, Marshall University, Hospital Association, Medical Society, Department of Health, black lung program, Blue Cross-Blue Shield, United Mine Workers, and University Community Pharmacy Program. The program will establish methods to determine the prevalence of risk factors in two or more communities. Estimates of the prevalence of risk factors in each community will be provided by the West Virginia University Office of Health Service Research. Information will be collected from local organizations identifying those groups with prior experience in data collection or risk factor identification. Staff will meet with local organizatons to select volunteers to conduct a risk factor prevalence survey. These volunteers will be trained in survey techniques to conduct the survey for risk factor prevalence. The community surveys will be completed and all forms returned to the State-level program for data processing, and survey results will be distributed to the communities. The State-level program will identify existing sources of data relating to chronic disease morbidity and mortality prevalence risk factors. Data available from other State agencies will be compiled for review to determine which items are pertinent to the risk reduction program and which items might be added to improve surveillance. Morbidity data and risk factor prevalence data available from other public and private agencies will be identified, accessed, and reviewed. Data collected from public and private agencies will be used in determining specific risk factors to be addressed by intervention projects and will be aggregated and available for use by other agencies such as the State Health Planning and Development Agency and the Health Systems Agencies. The State-level program will stimulate two communities to undertake an organized approach to risk reduction and by July 15, 1981, will provide technical assistance in surveying, data processing, and selecting intervention projects. The organizations from communities willing to take an organized approach to risk reduction will be given written definitions of an organized approach to risk reduction. Participating

community organizations will receive verbal and written notices of funding priorities established for intervention projects by CDC. The HERR program, through consultation with the State Advisory Committee, will select two communities which will receive extensive assistance to undertake an organized approach to risk reduction.

81P-0663
RAP: Rural Radio Adolescent Alcoholism Prevention Program.
Pocahontas County Health Department, WV
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

RAP (Rural Radio Adolescent Alcoholism Prevention Program) is designed to (1) determine the prevalence of risk factors in the target population (Pocahontas County youth, 1,050 of elementary school age, 500 of middle school age, and 750 of high school age); (2) use radio to promote healthy attitudes and behaviors; (3) actively involve youth in the production of a series of radio programs, thereby aiding in the development of positive personal and community identities which will tend to lessen dependence on tobacco, alcohol, and drugs; (4) distribute radio programs to other West Virginia counties if they are successful; (5) involve relevant community agencies and groups as consultants in the project, to develop a coordinated community effort to deal with local substance abuse problems; and (6) address other health factors in subsequent program years. To accomplish these goals, the program will (1) involve 30 high school youth and 20 middle school youth in the development, production, and broadcast of health education spot announcements, brief program modules, and live interview call-in shows; (2) produce, working with school-age youth, at least fifteen 30-second spot announcements and at least six 3- to 5-minute program modules of sufficient programmatic interest and technical quality for distribution to radio stations in other communities; (3) broadcast materials developed in this project on a regular basis on WVMR, a local noncommercial radio station; (4) work with interested agencies and individuals and develop an organized, communitywide approach to smoking and alcohol risk reduction; (5) administer questionnaires on smoking and alcohol prevalence, knowledge, and attitudes to students in grades 5, 8, and 11 at the outset of the project; and (6) focus on alcohol and smoking initially, and expand the program to include other risk factors in subsequent years. Publicity and public information materials will be developed for distribution to accompany radio material. An impact evaluation will be performed using a pre- and post-project instrument designed to measure risk factor prevalence, objective knowledge, and attitudes toward risk. Initial administration of the instrument will be in October 1980, with plans for administration each September in subsequent years.

WISCONSIN

81P-0664
Health Education-Risk Reduction (HERR) Grant Project, Wisconsin.
Imm, I. E.
Wisconsin Department of Health and Social Services, Division of Health, Bureau of Prevention, P. O. Box 309, 1 W. Wilson Street, Madison, WI 53701
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Wisconsin was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. In FY 1980 a letter and questionnaire were sent to 4,000 agencies with potential interest in risk reduction. The list was developed with input from HSA's and the State Departments of Social Services, Regulations, and Public Instruction. A directory format was chosen, after reviewing existing inventory resources, to facilitate updating and accessibility of data. The format will be a loose leaf notebook with separate volumes for each of the State's seven HSA's and will be arranged alphabetically. Selected volumes will be distributed to HERR grantees, local health agencies, and HSA's. By August 1981 the number of entries will be increased by 20 percent by following up with any of the 4,000 agencies not responding to the 1980 survey, integrating the inventory with the annual survey of public health agencies conducted by the Bureau of Community Health, and increasing the number of agencies surveyed by 500 to be selected from health insurers, HMO's, municipal agencies, and labor unions or chambers of commerce. During FY 1981 the HERR staff will identify the minimum cost method for maintaining the directory and will initiate a request with the State's Office of Information Systems to develop the cost-minimizing system.

Beginning FY 1981 a file of State-level working relationships will be established and maintained. It will include minutes of the Interdivisional Task Force on Risk Reduction Planning, documentation of participation, the department's risk reduction coordination plan, and letters of agreement and support from various statewide agencies. By January 1981 the State will contact by mail or meet with statewide agencies interested in risk reduction in order to communicate the State program's goals, objectives, and methods. By December 1980 a system to measure the prevalence of risk factors in communities, which is necessary for the development of community risk reduction objectives and assessment of program impacts, will be operational as demonstrated by a completed Community Health Risk Measurement System Guide, survey instrument incorporating the CDC-recommended Common Data Items, and an analysis plan. Prior to this, by November 1980 it will be determined whether the CDC's Common Data Items will be part of the statewide Health Status Survey of 1980 or an alternate plan. By March 1981 the System will be pilot tested in two communities taking an organized approach to risk reduction, and the State will have the capacity to provide technical assistance to communities using the system. By May 1981 all communities awarded HERR intervention funds will implement the system. During FY 1980 efforts were directed at identifying existing data sets within the Wisconsin Division of Health and establishing a permanent liaison between the Bureau of Health Statistics and the HERR. By June 1981 the State will complete an investigation of data resources related to chronic disease, other preventable health conditions, and risk factors that exist outside the State Division of Health and compile a report of this information. From the initiation of the program, the State sought to identify communities already well organized in the area of health promotion. Eleven communities (17 agencies) were identified in which the elements were in place or could be easily incorporated. By March 1981 at least five additional communities will initiate efforts to take an organized approach to risk reduction as evidenced by letters of commitment. In the meantime, by January 1981 the State will provide program manuals and conduct onsite visits to communities that are interested in an OARR. By August 1981 all agencies which have written commitments will demonstrate a strong interagency working relationship by 1) establishing a set of objectives for reducing risks in the community, based on the "Model Standards for Community Preventive Health Services"; (2) assessing major nonhealth promotion program influences on health-related behaviors in the community; and (3) planning and conducting a community health promotion fair utilizing various resources of all the agencies undertaking an OARR. Beginning October 1981 the State will monitor and record indicators of progress toward community and State objectives. By May 1981 the State will audit requests for assistance to ensure sufficient resources for FY 1982.

81P-0665
Children's Intervention Program.
United Community Center, Joint Drug Program, Milwaukee, WI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Children's Intervention Program is designed to (1) educate children about the hazards of and alternatives to the use of alcohol and tobacco; (2) develop educational presentations about these substances and hazards using puppetry; (3) train 125 4- to 12-year-old children to use puppetry and develop scripts and perform shows about smoking and drinking; (4) train staff (64 persons) who work in various agencies in the use of puppetry as an educational tool; and (5) develop a bilingual collective that all agencies can use for their own references on the use of alcohol and cigarettes. To accomplish these goals, the program will (1) train puppeteers in pilot workshops; (2) incorporate and continue the program in the community agencies that have agreed to work with the Joint Drug Program; (3) through puppetry, teach the side effects and hazards of alcohol and nicotine; and (4) include parents in the audience and have liaison persons on hand to direct parents to resources in which they express interest. During the first 6 months, the project will operate the puppetry program; later, it will offer a straight informational program. Both systems of education will be pre- and posttested, with groups to be comparable in age and ethnicity. Scores will be compared at midyear. Subsequently, the group that received only informational programming, during the latter half of the program year, will receive the puppetry program. Again, the group will be pre- and posttested.

81P-0666
Project Com-Ed: Wisconsin Health Education-Risk Reduction Program.
Community Board of Outagamie County, Appleton, WI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

Project Com-Ed is designed to (1) deter students in eight target communities in Outagamie County from misusing tobacco and alcohol; (2) establish eight teams, one in each target community existing under Project Pre-Action; (3) train the individual youth and adult members of the teams on tobacco and alcohol community education topics, and

have them develop a plan for a community alcohol and smoking education conference; (4) encourage and assist community agencies in taking a community-organized approach to risk reduction; and (5) achieve a measurable (long-term) reduction of premature death and disability from chronic diseases and other preventable health conditions. To accomplish these goals, the program will (1) hire staff and establish the teams; (2) train 220-240 youth and adult volunteers who will then exert their influence on others through working in an organized community-based effort, and implementing a community health education conference directed at alcohol and tobacco use; (3) administer the community health risk measure; and (4) form a project policy committee of representatives from key organizations to meet quarterly to review the progress of the project. An evaluation will pre- and posttest each team member to ascertain knowledge and attitudinal changes; the State of Wisconsin Bureau of Prevention will approve the test instruments. If appropriate, random surveys of the community conference will be made to test conference quality. Ongoing process evaluations will be made by ascertaining the number of participants in the various training and education activities.

81P-0667
Red Cliff Health Education-Risk Reduction Project.
Red Cliff Band of Lake Superior Chippewa Indians, Bayfield, WI
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Red Cliff Health Education-Risk Reduction Project is designed to (1) decrease from 26.6 percent to 10 percent the proportion of women who use alcohol frequently during pregnancy; (2) decrease from 47 percent to 15 percent the number of women who smoke during pregnancy; (3) have 50 percent of the pregnant women participate in a structured exercise and weight control program; (4) have 75 percent of the pregnant women attend a series of stress clinics; (5) decrease by 20 percent the number of elderly who abuse alcohol; (6) decrease by 10 percent the number of elderly who smoke regularly; (7) enlist at least 10 elders in a program of regular exercise; (8) have 33 percent of the tribal elderly attend a series of stress clinics; (9) initiate health promotion activities that will induce elderly tribal members to follow treatment regimens and health maintenance programs; (10) decrease by 10 percent the number of youth using alcohol regularly; (11) decrease by 20 percent the number of youth who smoke; and (12) have a minimum of 50 youth participate in a series of stress clinics. To accomplish these goals, the program will (1) conduct needs assessment to determine the incidence and prevalence rates of disabilities, existing resources, and effectiveness in meeting demand and need lifestyle patterns; (2) maximize crisis intervention resources to meet the current and projected demand; (3) introduce stress management as a way of life; (4) integrate projected health service system needs into the overall economic plan of the tribe; (5) maximize rehabilitation resources through networking with county, State, and Federal resources; and (6) integrate all health services to include health promotion as a way of life. The target group will consist of 650 pregnant women, elderly, and youth of the Red Cliff reservation, as well as those living immediately adjacent to it. The objectives are designed to be self-evaluating. Besides the State Health Education-Risk Reduction Program's evaluation plans, formative-process and summative-product evaluations will be conducted by the Red Cliff social planner and analyzed by human service consultants.

WYOMING

81P-0668
Health Education-Risk Reduction (HERR) Grant Project, Wyoming.
Parish, H. S.
Wyoming Division of Health and Medical Services, Disease Prevention and Environmental Services, Hathaway Building, Cheyenne, WY 82002
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1979 - Continuing.

The Health Education-Risk Reduction (HERR) Grant Project in Wyoming was established to (1) update and maintain an inventory resource of existing health education-risk reduction programs and services, (2) establish and foster working relationships among agencies, (3) determine risk factor prevalency data, (4) survey and establish systems for acquiring chronic disease morbidity and mortality data, and (5) help communities achieve an organized approach to risk reduction. An extensive inventory of health service organizations, health data, and contacts in health-related fields is maintained by the Wyoming Information and Referral Service. These data are current and available to citizens of Wyoming on a 24-hour basis via a telephone hotline. The State plans to negotiate a contract with the service and use it as a centralized repository of HERR programs and services. A directory of such activities will be compiled and available by

January 1, 1981. The State plans to establish liaisons with voluntary agencies, professional organizations, and educational groups and to appoint an advisory council composed of representatives from public and private organizations to help implement the State HERR plan. A number of methods will be used including using information on cigarette consumption provided by the Wyoming Department of Revenue and Taxation to establish base-line data and to evaluate the success of antismoking campaigns; using information on alcohol consumption provided by the Wyoming Liquor Commission to establish base-line data and to evaluate the success of programs to decrease alcohol abuse; and conducting a survey in selected high schools on the prevalence of and attitudes toward smoking. The State will conduct formal written negotiations with public and private health agencies, e.g., the Vital Records Section and the Tumor Registry of the Division of Health and Medical Services, that will report morbidity and mortality data to the State. In efforts to achieve this goal, the State plans to establish the School Health Curriculum Project (Berkeley Model) as part of the health education curricula of the public schools and to develop intervention projects to deter children and adolescents from smoking and alcohol use.

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WASHINGTON AREA COUNCIL ON ALCOHOLISM AND DRUG ABUSE (WACADA) ALCOHOL-SMOKING RISK REDUCTION PROJECT: A PILOT PREVENTION PROGRAM FOR MINORITY AND HANDICAPPED SCHOOL STUDENTS
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81-0669--81-0816

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COMMUNITY HEALTH EDUCATION

81-0669
Health Education in Practice.
Anderson, D. C., ed.
London, Croom Helm, 207 p., 1979.

An overview of the operations of the National Health Service and the educational system, the two major organizations through which health education takes place in Great Britain, provides insight into the relationship between policy and practice. Topics include the practical implementation of a health education program; health education in the National Health Service; health education in the educational system; doctors and acquisition of clients' health knowledge; antenatal care, postnatal nursing, and the role of the midwife in health education; portrayal of the professional relationship; the classroom as a context for health education; discussions with patients about their diets; and the use of empirical materials in training. Numerous references.

81-0670
Health Education in Rural Alabama.
Bridgers, W. F.; Kronenfeld, J. J.; Charles, E. D., Jr.; Goodson, L.; and Klapper, M. S.
Bio-Sciences Communications 4(1):51-58, 1978.

Project HELP (Health Extension Learning Program), affiliated with Auburn University, the Medical Center of the University of Alabama at Birmingham, and the State Department of Public Health, is an approach to rural health care delivery in Alabama. The project operates under the premise that human disease prevention should not differ fundamentally from that successfully employed for other animals. The project has concentrated on only a few programs and has selected those that (1) are noncontroversial with respect to their efficacy, (2) require personal interaction and active participation, and (3) can be presented to large audiences. These include emergency and acute care training, cancer prevention and early detection, preventive dental hygiene, and early awareness of arthritis. The literature for each program utilizes a nonthreatening, positive approach, mostly in the form of flipcharts with large, pleasant pictures and a minimum of text, which is written at the fourth-grade comprehension level. 2 references.

81-0671
A Very Different Kind of Fair.
Clark, M.; Hager, M.; and Abramson, P.
Newsweek 95(20):97, May 19, 1980.

Since the mid-1970's, the National Health Screening Council (NHSC) for Volunteer Organizations has coordinated health fairs for detection of diseases and for educational purposes. Private firms, television stations, and various health agencies have joined to make health fairs a front line of preventive medicine. During one recent week, 300,000 Americans attended NHSC-sponsored fairs involving 100,000 volunteers. Health fairs have been designed to deal with the problems of the elderly, teenagers, or other special target audiences, and to provide annual physical examinations to large populations. Up to 35 percent of the people passing through a typical fair find that they need medical attention. Though some physicians have complained that the fairs are attempting to provide services that should be obtained only through physicians, fair sponsors always stress that the events cannot replace a visit to a physician's office. Moreover, the results of some fairs have indicated that some doctors fail to educate their patients properly.

81-0672
A Community-Based Approach to Preventing Stroke and Coronary Heart Disease.
Farquhar, J. W.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 28 p., (197-).

The Stanford Heart Disease Prevention Program (SHDPP) Three Community Study was conducted to compare two educational approaches to stroke and coronary heart disease prevention. One community received an educational intervention through the mass media, a second community received the mass media intervention plus individual intensive instruction in self-directed change methods, and a third community acted as a control group. To test the effects of the approaches, base-line surveys were conducted in each community prior to the first year of education, and yearly followup surveys were conducted for the next 2 years. For each survey, subjects were given a partial medical examination and interview to assess knowledge, attitude, and behavior regarding cardiovascular disease risk factors. The medical examination included measures of plasma cholesterol and triglyceride concentrations, blood pressure, relative weight, and electrocardi-

ograms. Results indicated that after 2 years of the treatment campaign, both treatment conditions yielded significant positive effects on all variables except relative weight. Implications for future educational programs are discussed.

81-0673
Meeting the Needs of the Parents of Children With Diabetes--A Babysitter's Course.
Giordano, B. P. and Edwards, L. L.
Diabetes Educator 6(3):26-27, Fall 1980.

Parents in the Juvenile Diabetes Foundation (JDF) of Denver, Colorado, enlisted the help of diabetes educators at two local hospitals to aid in developing a diabetes child care course. The course participants, potential babysitters for diabetic children, are junior high school students chosen and sponsored by parents of youngsters with diabetes. The students receive a handbook and participate in a 2-hour class on basic diabetes physiology, insulin action, food management, urine testing, and hypoglycemia. The educators plan class content and mode of presentation with a JDF parent, teach the class in cooperation with a JDF parent, evaluate participants' performance through a postclass test and urine-testing skills demonstration, and serve as a resource for parents and babysitters. Parents also evaluate the babysitters' ability to care for their children. Since the first class in October 1978, 50 area adolescents have completed the course. Parents who have employed participants have reported favorably on their responsible attitude, knowledge of diabetes, and observation skills. The course will be expanded to serve other child care providers who work with children for longer periods of time. 3 references.

81-0674
NAQ Forum: Outreach Programs: Past, Present, and Future.
Hongladarom, G.
Nursing Administration Quarterly 4(4):85-90, Summer 1980.

Community outreach can be a method of either case finding or of providing programs and services to cases already located. A major function of outreach programs is communication with the program's constituency through newsletters, telephone networks, media, or direct contact. All outreach program activities should have an evaluation component to provide substantiation for outside funding agencies and for internal budget personnel. Needs assessment is essential; programs not developed in response to documented needs are not likely to be successful. Since programs and their staffs are sometimes regarded with suspicion, workers must be aware of community customs and values and should identify and meet with individuals who have access to the community power structure. Regardless of an activity's scope and duration, a planning or advisory group is necessary. It should be composed of people who have expertise in the planned activity or who can serve as community liaisons. 4 references.

81-0675
Rehabilitation: Educating the Consumer.
Klebaner, R. P.
Journal of Visual Impairment and Blindness 71(7):315-317, September 1977.

Specialized community rehabilitation agencies for the visually impaired can provide settings in which the needs, rights, and expectations of the visually handicapped consumer (VHC) can be satisfied. The VHC needs to feel welcome, and needs courteous attention and education, information, and a variety of experiences, provided in a supportive environment. Specific components of each VHC's rehabilitation system can be assembled, including a well-formulated catalog of educational offerings, social and physical fitness programs, and resource information specifically related to the needs and interests of the visually impaired.

81-0676
Mass Communication and Community Organization for Public Health Education.
McAlister, A.; Puska, P.; Koskela, K.; Pallonen, U.; and Maccoby, N.
American Psychologist 35(4):375-379, April 1980.

As a result of cooperation between psychologists and public health researchers in the United States and Finland, a nationwide program to facilitate smoking cessation was conducted in Finland. The program consisted of a series of televised counseling sessions and an effort to organize volunteer-led, self-help viewing groups. Survey data suggest that about 40,000 adult smokers actively participated, and that 10,000 achieved at least 6 months of cessation. The percentage of women smoking 20 or more cigarettes daily decreased from 20.8 percent to 14.5 percent, and the number of men who considered themselves moderate smokers decreased from 29.2 percent to 24.4 percent. The usefulness of community organization for increasing participation was demonstrated by comparison between a province in which intensive organizing efforts were conducted and one in which minimal efforts were

made. Implications for the cost-effective delivery of other forms of behavioral and psychological counseling are discussed. 21 references.

81-0677
An Evaluation of the Role of Pre-School Clinics.
Rodrigues, O. and Rodrigues, A.
East African Medical Journal (Nairobi) 54(1):38-43, January 1977.

The activities of a rural preschool clinic in Tanzania were assessed. The clinic team consisted of one qualified nurse-midwife, three auxiliaries, and one driver at the outstation. Clinic services included weighing, immunization, treatment of minor illnesses, malarial prophylaxis, health education, and distribution of supplementary foods. Rates of weight gain, the average period of contact with the clinic, and the average number of visits were computed for 122 children. Data did not reveal any demonstrable effect of clinic activity on children's growth rate, suggesting that in a situation of resource scarcity, the preschool clinic should be assigned a role in nutrition surveillance rather than intensive education. 10 references.

81-0678
Things Go Better With Coconuts--Program Strategies in Micronesia.
Rody, N.
Journal of Nutrition Education 10(1):19-22, January-March 1978.

A 2-year nutrition education program was initiated in Micronesia, a U.S. trust territory in the Western Pacific, to promote increased utilization of indigenous foods and to discourage the use of expensive and nonessential imported foods. The latter practice has been related to nutritional problems that are sometimes severe. Emphasis was placed on practical methods of changing nutrition practices and attitudes. Motivational techniques using posters, newspaper and radio advertisements, and videotapes resulted in the reduction of soft drink importation and an increase in breast-feeding, as measured by tax receipt data for soft drink consumption and through clinical observation of changes in infant feeding practices. By enlisting the active participation of community leaders and respected institutions and by recognizing popular political views, support was achieved that enhanced the efforts to modify food behavior through personal value changes. 13 references.

81P-0679
Community Health Education Center.
Dansky, K.
Hocking Technical College, Nelsonville, OH 45764
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta; Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
1977 - Continuing.

The Community Health Education Center provides screening, information, and counseling services as well as educational programs on child health, weight control, physical fitness, arthritis, and heart health. Blood pressure and diabetes screening and education are offered, and media campaigns provide public education and encourage people to follow the regimens prescribed for high blood pressure and diabetes. Seminars for physicians are also provided. The center conducts workshops in child health, for parents and day-care teacher aides, and in physical fitness program development, for use by local industries. Center facilities include classrooms, an auditorium, a media center, a library, and a gymnasium. Residents living in Athens, Hocking, Perry, and Vinton Counties, Ohio, are served.

81P-0680
East Coast Migrant Health Project (ECMHP).
Ebbing, M.
National Migrant Worker Council, 1234 Massachusetts Ave., N. W., Washington, DC 20005
Funding Source: Department of Health and Human Services, Philadelphia, Pa. Region III.
1970 - Continuing.

The East Coast Migrant Health Project, created in response to a study suggestion by Region III of the Department of Health and Human Services, works with health care providers to serve migrants and seasonal farmworkers. The project provides health care professionals during peak seasons, when local health care facilities are usually overwhelmed. Project staff assess migrant campsites and rural bases to prevent duplication of services. The project's 6 service sites serve 133,000 migrants working in 20 counties in seven States. Depending on the area being served, 40-100 percent of the clientele speak Spanish as their primary language. Project staff members, 50 percent of whom are bilingual, include physicians, nurse practitioners, community nurses, nutritionists, health educators, community social service workers, licensed practical nurses, and health aides. The success of the program has been evident in the project's ability to recruit bilingual staff, recruit migrant workers to serve on policy-making boards, provide full-time staff members to move with migrants, mobilize political and civic leaders to remove obstacles to health care for migrants, conduct Head Start programming for migrant children, establish a child care center in Florida, and direct prepaid insurance programs.

81P-0681
Mobile Dental Unit--Extramural Community Dentistry Program.
Jasper, W. J.
Baylor College of Dentistry, Department of Community Health and Preventive Dentistry, 3302 Gaston Avenue, Dallas, TX 75246
1974 - Continuing.

The Extramural Community Dentistry Program is a community outreach program designed to promote in dental students, dental hygiene students, and community members an awareness of and solutions to oral disease problems in the community. The program includes dental health education, a survey of individual and group dental needs, limited dental care treatment for deprived residents, and referral and followup dental care at area facilities. The educational component consists of 5- to 15-minute presentations on the importance of dental health, a review of Dallas-area dental care facilities, dietary influences and fluoridation, and techniques of oral hygiene. Facilities include a mobile dental unit and a stationary clinic. The target audience consists of underserved populations in the Dallas metropolitan area; 450-1,000 patients are served by the program each year. The program is supervised by a faculty dentist at the Baylor University School of Dentistry, and is staffed by students in the School of Dentistry. The program is evaluated by the students, and their performance is evaluated by the faculty. In addition, a summary of each week's operation is prepared.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-0682
Employees as Health Educators: A Reality at Kimberly-Clark.
Dedmon, R. E.; Kubiak, M. K.; Konkol, P. D.; Gander, J. W.; and Paschke, A. C.
Occupational Health and Safety 49(4):18-19, 21-24, April 1980.

Updated information is provided on employee health status and participation in the Kimberly-Clark Corporation's Health Management Program. As of January 1980, approximately 2,700 employees had undergone multiphasic screening and exercise tests; 4,000 had undergone treadmill or bicycle ergometer exercise tests; and 4,000 had been screened for cancer via chest X-rays. The key factors of the program are (1) participation by senior management and the medical staff, (2) persuasive and valid communications to encourage participation, (3) application of educational diagnosis and evaluation with practical behavioral objectives, (4) a simple information system for program evaluation, (5) cooperation with other companies in data sharing, (6) training programs for staff, (7) miniscreening and maxi-evaluation, (8) development of effective educational and marketing strategies to promote behavior change, and (9) procurement of support from employees' private physicians. Studies are underway to assess program impact on cardiovascular risk factors, absenteeism, and health care costs. Base-line data are being established that can be followed by trend-line regression analysis for a 10-year period.

81-0683
Believing in Seeing.
Hibbs, G.
Occupational Health (London) 31(11):512-518, November 1979.

An outline of an occupational health education strategy for promoting eye and vision protection addresses questions about target audiences for educational and promotional efforts, forms of promotion and education, material aids designed to reinforce the educational experience, and sources of information for the health educator. When planning or implementing a program, the educator should approach top management personnel, all health care staff, other health and safety personnel and specialists, division heads and department managers, service personnel, and people at risk. Effective teaching techniques include formal talks, screening tests, diagnostic eye test and treatment programs, peer group pressure mobilization, and visits to other departments to show interest in their work. Materials that will aid the educator in reaching the audience include films, filmstrips, slides, videotapes, sound recordings, overhead projectors, chalkboards, magnetic and felt boards, displays, models, pamphlets, posters, instruction sheets, shop handbooks, rule books, safety manuals, first aid box instructions, and in-house magazines. Occupational health educators can find information pertinent to their interests through public and postgraduate medical center libraries, courses advertised in nursing and safety publications, the local health education office, local physicians, and pharmaceutical wholesalers.

81-0684
Risk Factor Reduction By Biofeedback in the Factory.
Marmot, M.; Patel, C.; Terry, D.; Carruthers, M.; and Sever, P.
Journal of Psychosomatic Research (Oxford) 23(6):433, 1979.

A study was conducted to (1) test the feasibility of biofeedback-aided relaxation in lowering blood pressure in an industrial setting, by using healthy subjects with mild hypertension; and (2) assess the effect of biofeedback in reducing cholesterol intake and cigarette smoking. Subjects with serum cholesterol exceeding 6.3 moles per liter, systolic blood pressure greater than 140mm Hg, and a smoking habit of more than 10 cigarettes a day were randomly assigned to either biofeedback or control groups. The biofeedback group received eight weekly training sessions; both groups received health education literature. At an 8-week followup, the biofeedback group demonstrated significant reductions in blood pressure and cigarette smoking, and a small reduction in plasma cholesterol. In addition, biofeedback appeared to affect plasma renin activity and plasma noradrenalin. A 6-month followup evaluation is planned.

81-0685
One Corporation's Pursuit of the Physical and Psychological Dividends of Fitness.
McKinney, J.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 10 p., (197-).

The Texas-based Tyler Corporation has been identified with individual physical fitness promotion, particularly through its support of the Institute for Aerobics Research in Dallas. The overall purpose of the Institute for Aerobics Research is to quantify the effects of exercise in prevention or delay of coronary heart disease. Because of an immense data base, the institute staff believes it will be able to present a convincing case demonstrating an inverse relationship between fitness levels and coronary risk factors. Aerobic fitness can increase executive productivity through increased cardiovascular strength, mental capacity, and self-confidence. Additionally, the Tyler Corporation encourages the use of psychocybernetics as a means to utilize the subconscious to foster a positive self-image, which increases the likelihood of successful business ventures. The institute believes a synergistic relationship exists between aerobics and psychocybernetics that can enable individuals to use subconscious mental and physical power.

81-0686
Making Good "Cents" Out of Hearing Conservation.
Niswender, M. E.
Occupational Health and Safety 49(3):57-60, March 1980.

Guidelines for establishing cost-effective workplace hearing conservation programs are presented. Indoctrination into the steps of hearing conservation involves management first, and then the line supervisors and workers. Key educational efforts may take various forms, such as training sessions for supervisors or take-home brochures for employees about company policy towards noise control. Research indicates that the best ways to ensure the use of hearing protection devices are (1) providing more than one protection device; (2) interpreting the employee's hearing status; and (3) promoting the benefits of hearing protection. A joint statement of policy by management and medical and nursing staff on employee health counseling and referral by the nurse is essential. "Identification audiometry" (as opposed to diagnostic audiometry) as a means of hearing protection has three parts: (1) base-line audiometry, which is the first record of the employee's pure tone thresholds and is made on entry into the company; (2) interval and preplacement audiometry, in which thresholds are redetermined for each employee at selected intervals; and (3) exit audiometry, in which an audiogram is recorded at the employee's final discharge. 6 references.

81-0687
The Emerging Role of the Occupational Physician in Preventive Medicine, Health Promotion and Health Education.
Pearson, C. E.
Journal of Occupational Medicine 22(2):104-106, February 1980.

Advantages of health education in the workplace are discussed, and guidelines for the establishment of industrial health programs are presented. The impetus for program initiation usually comes from the occupational physician, who must determine the health education needs of the company, its employees, and the surrounding community. The physician must then decide how quickly results are needed and whether the program should be highly visible. Educational techniques can include personal counseling in conjunction with periodic examinations, films, and printed materials. The most common source of financing is the company medical department, although some programs are funded through prepaid health or insurance benefits. Evaluation techniques include (1) administering questionnaires to determine perceived program effectiveness, followed by one-to-one discussions; (2) surveying medical department reports longitudinally; (3) listening to members of the audience during discussions; (4) examining private physicians' reports; and (5) determining the degree of employee participation in community health projects. Evaluative measures can indicate whether a program has

helped to reduce workmen's compensation payments, illness-related absenteeism, or hospital and medical expenses.

81-0688
Time Out From Tension.
Peters, R. K. and Benson, H.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 5 p., (197-).

A 12-week study tested the feasibility and usefulness of voluntary relaxation response breaks in a working environment. One hundred and forty volunteers and fifty-four nonvolunteers, selected at random to help with program evaluation, were selected from 428 corporate employees at the Converse company in Wilmington, Massachusetts. Volunteers were asked to keep daily records for the 12 weeks and to attend seven biweekly sessions, during which they would fill out questionnaires and undergo blood pressure measurements. Nonvolunteers agreed to undergo blood pressure measurements and to complete questionnaires at the beginning and end of the study. Volunteers were divided randomly into groups A, B, and C; nonvolunteers made up group D. Group A was taught a technique for eliciting the relaxation response; group B was instructed to sit quietly and relax; and groups C and D received no instructions and were told to follow their usual schedules. In the subsequent 8 weeks, groups A and B were asked to take two 15-minute relaxation breaks daily. Blood pressure, general health, performance, and well-being were assessed. Results revealed that significant decreases in blood pressure occurred only in group A. The greatest average improvements on the health, performance, and well-being indexes also occurred in group A. Results suggest that relaxation breaks alleviate stress-related problems and that both individuals and industries would benefit from their implementation. 5 references.

81-0689
Health Carnival: An Experiment in Health Education.
Wear, R. F., Jr.; Hawley, R. C.; and James, M.
JOM. Journal of Occupational Medicine 22(4):253-255, April 1980.

Health education was offered to Campbell Soup Company employees and their families through the Campbell Soup Health Carnival, in which active participation and demonstration were employed to stimulate interest and promote learning. Exhibits had posters and take-home materials on heart attack, hypertension, common lung diseases, cancer of the colon and rectum, carcinoma of the uterus, breast cancer, exercise, trauma, and alcohol problems. Additional features included a breast self-examination movie, lecture, and demonstration; a tape on relaxation; blood pressure measurement; and medical counseling by a nurse specialist. The "Family Health Handbook," which discusses health promotion topics and common medical problems, was given to all families. Results from a postcarnival questionnaire revealed that 95 percent of respondents thought the carnival should be repeated, 43 percent reported that family health habits had improved, and 32 percent read most of the handbook.

81-0690
What Is Meant by "Counselling."
Williams, M. M.
Occupational Health (London) 32(1):38-43, January 1980.

The role of counseling in basic nursing care is examined, and research on occupational health nurses' understanding of, and commitment to, counseling is summarized. Results from a survey of 30 occupational nurses in varying services revealed that (1) as a group, they spent only 5 percent of their worktime on counseling; (2) 30 percent of all time was spent with patients; (3) 63 percent of problems brought to the nurse were about health, while 34 percent were concerned with personal relationships; (4) counseling services were divided evenly between the sexes; and (5) the essential aspect of counseling was client privacy. 23 references.

HEALTH EDUCATION METHODOLOGY

81-0691
Lifetime Health Related Physical Fitness--Test Manual.
American Alliance for Health, Physical Education, Recreation and Dance, Reston, Va.
Reston, Va., Alliance, 71 p., 1980.

Guidelines for assessing physical fitness are offered that allow individuals to test their cardiorespiratory function, body composition, and abdominal and low back-hamstring musculoskeletal function. The test items used to assess cardiorespiratory function are the 9-minute 1-mile run and the 12-minute 1.5-mile run; the test item used to assess leanness or fatness of body composition is the sum of tricep and subscapular skinfolds; the test items used to

assess abdominal and low back-hamstring musculoskeletal function are the sit-and-reach exercise and the modified, timed situp. In addition, the guidelines offer means of maintaining and developing physical fitness via principles on exercise and physical fitness development and specific guidelines for the physical fitness components. Exercise recording forms and construction procedures for sit-and-reach apparatus are appended.

81-0692
A History of Teaching by Television.
Appleby, R. C. and Appleby, D. C.
Iowa Dental Journal 64(2):18-21, April 1978.

A review of research concerning the use of television for educational instruction is presented, with emphasis upon televised dental instruction. Television can be used in dental instruction not only to teach students in the classroom, but also as a psychotherapeutic tool to reduce the fear that some children associate with a visit to the dentist. Specifically, films can be shown in which characters model appropriate behavior. 31 references.

81-0693
Adaptation of Nutrition Educator Determined Objectives for Learner Developmental Levels.
Bell, P. E.
San Francisco, Calif., American Educational Research Association Annual Meeting, 13 p., April 1979.
Available from: ERIC; Order No. ED-171 672.

A curriculum development process for nutrition education, similar to that used by the National Science Foundation in the late 1950's and 1960's, was initiated in grades K-12. The primary features of the process involved heavy emphasis on extensive student involvement in learning activities; reliance on research scholars for development of the curriculum; and production of a detailed, comprehensive, longitudinal program. The curriculum focused on formation of norms in communication and emphasized tolerance rather than acceptance of cultural pluralism. In addition, the curriculum was designed to (1) set nutritional standards, (2) be adaptable to various subject areas, (3) be composed of exemplary instructional segments, (4) be flexible regarding modes of presentation, (5) encourage teachers to develop their own ideas, (6) include instruction for teachers that exceeds that presented to students, (7) address the teacher rather than the student, and (8) involve as little teacher preparation as possible. Pilot programs designed to test the curriculum's acceptance by students, teachers, and administrators as well as its impact on parents and the community are being implemented. 26 references.

81-0694
The Cold Clinic--An Attempt, A Realistic Concept?
Bigelow, A. T. and Morton, M.
Journal of the American College Health Association 29(2):89, October 1980.

For several semesters, the student health service at State University College of Arts and Sciences in Plattsburgh, New York, has examined means to treat the common cold. A visit by health service staff with drug company representives revealed that many companies were willing to supply a "cold table" with samples of many over-the-counter decongestants and analgesics. The cold table has shortened clinic waiting lines and has facilitated more effective use of health professionals' time. Due to the success of this self-education approach, first aid, intestinal, and personal hygiene tables might also be tried. Another approach to wellness education is weekly article written for the campus newspaper that discusses common health problems encountered by the health service and answers health questions from students. Other approaches can utilize the campus mass media, with radio and television spots prepared by different health organizations. Educational television has allowed panel discussions to be recorded and broadcast to students in the local area. Each wellness education concept has been well received by the student body.

81-0695
Dial A-L-C-O-H-O-L and Jackson Junior High: Adult Group Leader Guide.
Finn, P.; Lawson, J.; and Abrams, L.
Washington, D.C., Office of Education (DHEW), Division of Educational Technology; Rockville, Md., National Inst. on Alcohol Abuse and Alcoholism (DHEW, ADAMHA), 53 p., 1977.
Available from: ERIC; Order No. ED-170 655; and GPO; Stock No. 017-080-01773-3.

Guidelines are offered for those who assist professionals working with adults in alcohol education. Although originally developed for use with junior and senior high school students, the materials presented contain pertinent information about alcohol use, deal with significant issues related to alcohol abuse, and provide examples of behavior associated with drinking. The guidelines include learning activities that focus on previews, highlights, and followup procedures; information about alcohol and alcohol education; and resources for obtaining further information about alcohol and alcohol education. Synopses of films that can be used to reinforce the suggested activities are provided.

81-0696
Gulp--An Alternate Method for Reaching Teens.
Mapes, M. C.
Journal of Nutrition Education 9(1):12-16, January-March 1977.

A 1973 survey matched the nutritional concerns of 281 New York State teenagers with their design and format preferences for creating a nutrition comic entitled "Gulp." In a followup study in 1974-75, involving 312 8- to 14-year-old and 409 14- to 18-year-old students, as well as their teachers, group reaction to "Gulp" as a nutrition education tool was determined. All students were able to select the intended message of three book episodes: body image, soft drinks, and fad dieting. Lower ability and younger students expressed difficulty in understanding some of the vocabulary and subtle humor, causing many teachers to estimate the ideal age for comic usage as somewhere between 14 and 16 years old. Nutritional concerns of greatest interest were ways to lose weight quickly, diet in relation to acne, and snacking. Most teachers felt Gulp was original, informative, and thought provoking and could be used effectively as a nutrition teaching tool with some simplification of vocabulary and page design. 16 references.

81-0697
Vegetebella--A Nutrition Musical for Young and Old.
McCauley, J. and Smith, M.
Journal of Nutrition Education 9(1):18-19, January-March 1977.

Vegetebella, a full-length nutrition musical, was written and directed by two University of Delaware nutrition students as an independent project for a community nutrition course. The musical includes information on the four food groups, caloric value, principles of food budgeting, and critical analysis of food advertisements. Although the musical was originally conceived for elementary schoolchildren, audience members of all ages have enjoyed the performance, partly due to the casting of elderly residents. As a result, the elderly also learned nutrition principles. Various audience and cast remarks indicated an increase in nutrition awareness.

81-0698
On Control.
Mittelman, B.
Dental Management 19(3):85-86, March 1979.

The use of newsletters to provide dental patients information about oral hygiene, nutrition, and periodontal disease is examined. This format provides (1) a means to share information outside of limited office time, (2) a means for quoting information sources verbatim, (3) a vehicle for reinforcing important ideas by rephrasing them and by quoting outside references, (4) a forum to advocate an overall healthy lifestyle through good nutrition and exercise, and (5) a way to build a good relationship between staff and patients. Although a few staff members may take responsibility for organizing and writing the newsletter, all members should contribute ideas. To increase readability, articles should avoid technical jargon and be presented in a two-columns-per-page format. Details are given on how to publish and distribute such a newsletter.

81-0699
Nursing Assessment and Health Promotion Through the Life Span.
Murray, R. B. and Zentner, J. P.
2nd ed. Englewood Cliffs, N. J., Prentice-Hall, 448 p., 1979.

Nursing intervention methods are presented, focusing on measures to maintain health, and emphasizing an understanding of normal growth and development as a reference for assessment and intervention. Physiological concepts, psychosocial concepts, family development and relationships, and nursing implications are examined for assessing and promoting the health of infants, toddlers, preschoolers, schoolchildren, adolescents, young adults, middle-aged persons, persons in later maturity, and persons nearing death.

81-0700
An Ounce of Prevention: A Course for Blacks--Facilitator's Handbook.
National Center for Alcohol Education, Arlington, Va.
Rockville, Md., National Inst. on Alcohol Abuse and Alcoholism (DHEW, ADAMHA) (DHEW Publication No. (ADM)77-454), 83 p., 1977.

Guidelines for facilitators in courses about decision making as it relates to alcohol use among blacks are presented. The guidelines include background notes on group norms, group participation, course assumptions, awareness of attitudes about drinking, organization of course materials, methods of presentation, suggestions for handling group discussions, presentation media, roles of the facilitator, and implementation of the course session. The eight course sessions address myths and realities concerning alcohol use and abuse; influences of American history and popular media on drinking behavior; reasons for drinking; effects of alcohol on bodiiy functions; effects of mixing alcohol with other drugs; social drinking versus antisocial

drinking; relationship between self-images and decision-making processes; and influences of family, peers, and background factors on decision making about drinking. A list of alcohol education resources is appended.

81-0701
Health Information Resources in the Department of Health and Human Services, 1980.
National Health Information Clearinghouse, Washington, D.C.
Washington, D.C., the Clearinghouse, Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine (PHS, DHHS) (DHHS Publication No. (PHS)80-50146). 100 p., 1980.

A guide for health care professionals lists and briefly describes 76 Federal and federally sponsored health information resources in the U.S. Department of Health and Human Services. Included in each entry, contingent upon the availability of pertinent information, are name and address of resource; name and telephone number of the individual or office handling inquiries; the Federal sponsor; authorizing legislation; target audience; a brief description of the resource, its goals and services, its major projects or activities, and types of publications produced; the name, type, and frequency of publications; a description of the resource's data base; and any limitations on resource use or service charges.

81-0702
Commonwealth Edison Looks at "Coping."
Regan, L. C.
Proceedings of the Institute of Medicine of Chicago 33(1):16-17, January-March 1980.

To combat a growing void in public health information programs in the Chicago metropolitan area, the Institute of Medicine of Chicago and Commonwealth Edison began a cooperative sponsorship of a television-based preventive health series in 1974. Entitled "Coping," the program is designed to demonstrate how people can cope with a variety of emotional, personal, and spiritual problems. The series is videotaped and aired monthly on a local station. Program topics have included sexual dysfunction, the Heimlich choking maneuver, psychological problems, a heart and exercise plan, skin disorders, and birth control. The involvement of utility personnel, medically affiliated persons, and a nationally known science journalist creates a balance and perspective for the series. Commonwealth Edison keeps a videotaped copy of each program, which is used by the company's industrial relations department, hospitals, medical schools, health organizations, and a cable television station. Total cost to plan, produce, and promote the program is less than $55,000 yearly, and most of the money is spent on ads.

81-0703
Health Education.
Richards, P. R.
Community Health Studies 4(2):121-127, June 1980.

The organization and management of health education in Australia is examined, and factors that can influence health education program planning are discussed. A program to encourage behavior change throughout a community should be based on small groups and should encourage the active involvement of group members. An effective community health education program has three phases: (1) a cognitive phase, in which information is imparted through a medium shown to be best suited to the target group; (2) a communication phase, which involves communicating with small groups; and (3) an action phase, in which the health educator becomes associated with community opinion leaders who in turn work with the community to meet program goals. A holistic approach to any health education problem will incorporate a variety of interested parties into program planning. A necessary component of any properly planned program is an effective, complementary political lobby to urge the introduction of any needed regulatory measures. The need for changes in health education funding priorities is discussed. 5 references.

81-0704
Let's All Join the Lucky People; Proceedings of the Thirteenth Annual Meeting of the Society of Prospective Medicine, San Diego, California, September 29-October 2, 1977.
Society of Prospective Medicine, Indianapolis, Ind.
Bethesda, Md., Health and Education Resources, 128 p., January 1978.

Proceedings of the 13th meeting of the Society of Prospective Medicine cover the following topics: a health risk profile of the Society of Prospective Medicine; the credit-debit system of health hazard appraisal (HHA); limitations and new directions of HHA for risk assessment; a culture-based approach to the improvement of health practices; risk factors in coronary heart disease; reconstruction of HHA on a colorectal cancer model; updating tables on the probability of dying within next 10 years; an integrated HHA program; and the statistical hazards of HHA. Also presented are a comparison of seven methods of HHA; comparative mortality data in a multiethnic population; a

marketing perspective for prospective medicine; selling of optimal health; aging and cancer; clinical guidelines for smoking modification; planning cycle for the development of the Canadian HHA program; modification of drinking behavior; Kimberly-Clark's health management program; the high-level wellness concept; smoking cessation; and prediction of behavior change leading to risk reduction. The proceedings also cover HHA and the evaluation of lifestyle change programs; effects of an experimental personal health education course and HHA on selected college students in Illinois; measurement of precursors and factors influencing compliance; a randomized controlled trial of the ability of HHA to stimulate appropriate risk reduction behavior; a 2-year followup study on changes in risk behavior; a national overview of health education; comparative data on risk reduction for 1975-77; and a report on the use of HHA with a group of health professionals.

81-0705
Health and Higher Education. The Motivational Factor.
Southern Regional Education Board, Atlanta, Ga.
Regional Spotlight, 9 p., February 1977.
Available from: Eric; Order No. ED-149 666.

Since lifestyle contributes to the diseases from which most Americans die, health education rather than more medical services appears to be the most appropriate response. Although universities are fitting sources to educate the public about health, there appears to be no consensus regarding curricula for future health educators. Issues such as the relative amounts of academic preparation in technical health information versus behavioral intervention techniques need to be addressed, as well as the different strategies for educating the public about health. The jobs of health educators and primary health providers are reviewed, focusing on areas of needed improvement and community service. Initiatives taken by various institutions and examples of health education at the grassroots level in southern States are cited.

81-0706
Effects of Certain Training Parameters on Detection of Simulated Breast Cancer.
Stephenson, H. S.; Adams, C. K.; Hall, D. C.; and Pennypacker, H. S.
Journal of Behavioral Medicine 2(3):239-250, September 1979.

To develop a training technology for breast self-examination, 42 female subjects, organized into 14 groups, palpated a silicone breast model in a lump detection task. Dependent measures for each subject were trial duration, percent of lumps detected, and detection threshold (smallest lump detected 50 percent of the time). The effect of various practice modes on detection performance in the first of two posttests was evidenced by an increase in the percentage of detected lumps and a decrease in the detection threshold, with no practice mode proving superior. Following the first posttest, a brief search-training procedure was administered to 39 subjects. This procedure further lowered the detection threshold, increased the percentage of lumps detected, and increased trial duration in the second posttest. Results demonstrate the training procedure's effectiveness, and suggest the need for a more complex model to determine specific effects of the practice models employed. 6 references.

81-0707
Health Behavior, Health Education, Health Service Utilization and Compliance with Health Regimes: An Annotated Bibliography.
Toledo, J. R. and Hughes, H.
Denton, Texas, North Texas State Univ., 36 p., 1977.
Available from: ERIC; Order No. ED-177 092.

An annotated bibliography of printed material on health behavior, health education, health service utilization, and compliance with health regimes is presented for use by medical professionals and those concerned with health maintenance and behavioral medicine. 93 citations.

81-0708
Method and Design Issues in Evaluation of Community Health Education Programs: A Case Study in Breast and Cervical Cancer.
Windsor, R. A.; Kronenfeld, J. J.; Ory, M. G.; and Kilgo, J. S.
Health Education Quarterly 7(3):203-218, Fall 1980.

In 1976, breast and cervical cancer education was selected as a priority area by the Comprehensive Cancer Center of the University of Alabama at Birmingham. The center contracted with Project HELP (Health Extension Learning Program), a statewide community health education project, to develop, implement, and evaluate a cancer education demonstration program. With the assistance of medical oncology and educational specialists, the Project HELP staff developed and field-tested a 45-minute presentation on breast and cervical cancer. Program objectives included (1) increasing knowledge about cancer; (2) modifying health beliefs; and (3) increasing proper utilization of breast self-examination and Pap smears among female

participants in Calhoun County, Alabama. Results revealed positive changes in the treatment group on 2 of 11 cognitive items and demonstrated the utility of including evaluation procedures at an early stage of program development. Several methodological considerations, which merit the health educator's consideration in evaluating health education programs, are identified and examined, including (1) selection of design; (2) establishment of controls; (3) determination of sample size; (4) standardization of instruments; (5) selection bias; and (6) participant attrition. Implications for program development are discussed. 49 references.

PATIENT EDUCATION

81-0709
Medicine and Surgery at the Margin: An Inquiry Into the Causes of Overutilization.
Bunker, J. P.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 14 p., (197-).

A medical model of diminishing marginal benefits is presented as a means to curtail the overutilization of surgery and hospitalization. The model states that, as more funds are spent on medical care, less benefits are received, and a point is eventually reached at which costs and risks equal or exceed benefits. Surgical examples that fit the model include elective cholecystectomy, appendectomy, radical mastectomy, and inguinal hernia. Although the average patient is too poorly informed to play an effective role in medical decision making, solutions to the problem of overutilization will have to come, in part, from the public through awareness of medicine's limits. This awareness can be produced through massive educational campaigns that examine medical practice within the broad context of health and longevity determinants. In addition, overutilization can be curbed by changing the method of medical insurance reimbursement to fund only medical and surgical care of demonstrated efficacy.

81-0710
Monitoring and Facilitating Adherence to Hypertension Therapeutic Regimens.
Daniels, L. M. and Kochar, M. S.
Cardiovascular Nursing 16(2):7-12, March-April 1980.

Definitions of compliance versus noncompliance, assessment and monitoring techniques used successfully in a clinical setting, and adherence strategies are examined as they relate to hypertensive therapeutic regimens. Compliance can be measured through: (1) blood or urinary excretion levels of medication, metabolites, or markers; (2) designation of arbitrary compliance parameters based on research trends or earlier studies; and (3) pill counts, patient interviews, therapeutic or preventive regimen results, metabolic effects of therapy, and the clinician's estimates. Strategies that can facilitate adherence include (1) staff enthusiasm and commitment to hypertension control; (2) an accurate and efficient medical record and tracking system; (3) medication regimens that are minimally disruptive to the patient's lifestyle; (4) explanation of changes that the patient may expect as a consequence of therapy; (5) clear instructions about the patient's course of action if side effects occur; (6) joint negotiation of regimen activities and priorities; (7) incorporation of family participation and support; (8) use of behavior modification techniques; and (9) written clinician-patient contracts. Any combination of strategies may be applicable depending on the patient and significant others, health professionals, the clinical setting, and resources involved.

81-0711
Reaching an Interested Audience: Dental Education in Prenatal Classes.
Farrel, N. A.
Ontario Dentist (Toronto) 56(5):19-20, 22, May 1979.

"Dental Health of Moms and Babes To Be" is a dental public health program in Ontario, Canada, for expectant families and consists of 65 slides and a 21.5-minute tape. The presentation covers the expectant mother's oral health; the importance of primary teeth; thumbsucking and pacifiers; sugar, label reading, and dental decay; amount, consistency, frequency, and timing of sugar intake; brushing and flossing the child's teeth; topical and systematic fluoride; and dental visits for mother and child. Attendants are generally highly motivated couples who are receptive to the dental message. Recommendations following program implementation include: (1) dental information should be provided in university- and community-college-level nursing courses; (2) recommendations for fluoride supplements should be standardized; and (3) the slide-tape presentation should be donated to prenatal groups and hospital obstetrical units by local dental societies.

81-0712
Periodontal Considerations.
Gilson, C. M.
Dental Clinics of North America 24(1):31-44, January 1980.

A three-appointment periodontal approach to patients who require removable partial dentures is outlined, and the education, examination, motivation, and treatment of periodontal disease prior to undertaking restorative procedures is examined. In the first appointment, the patient's dental history, knowledge, and problems are discussed and the causes and treatment of dental disease are explained. During the second visit a complete clinical examination is conducted which evaluates the head, neck, and soft tissue; the periodontium; the hygiene status of the teeth, caries, and caries activity level; the occlusal relationship; the patient's response to periodontal irritation; poor dental hygiene; the amount of supporting structure remaining; functional gingiva and furcations; and the patient's attitude towards treatment. The third appointment centers around discussion with the patient concerning present dental health status, etiological factors, treatment procedures necessary to prevent disease recurrence, and negative factors affecting prognosis. The treatment plan which follows is divided into hygienic, corrective, and maintenance phases, each of which are briefly examined. 8 references.

81-0713
Patient Education Can Make a Difference.
Gugenheim, A. M.
American Lung Association Bulletin 66(4):2-5, May 1980.

Two case studies are presented which demonstrate how patients with emphysema and chronic bronchitis were helped through the use of the "Staff Manual for Teaching Patients About Chronic Obstructive Pulmonary Disease (COPD)." The manual, developed for health care teams, includes (1) general information on how to organize for patient education and how to evaluate its effectiveness; (2) discussions of chronic lung disease, including the pathophysiology of COPD; and (3) a review of common drug treatment therapies and exercise instructions. The manual also contains examples of patient handouts used to develop specific teaching instructions, and study questions and exercises to help professionals apply educational methods. The manual's contents were reviewed by the American Lung Association and the American Heart Association.

81-0714
Helping the Hypertensive Patient Control Sodium Intake.
Hill, M.
American Journal of Nursing 79(5):906-909, May 1979.

Guidelines are presented for nurses to help hypertensive patients control sodium intake. The guidelines emphasize (1) definitions of salt, sodium chloride, and other compounds containing sodium; (2) the relationship of sodium to high blood pressure and the rationale for eliminating sodium from the diet; (3) avoidance of foods and medications that contain multiple sodium compounds, and the importance of reading labels carefully; (4) dietary alterations such as limiting salt intake and calculating sodium exchanges; (5) preparation of food without using compounds containing sodium; and (6) consideration of salt substitutes with a physician's advice. In addition, a chart for sodium exchange calculation is provided and presents the sodium content per serving of selected foods. The flexible concept of exchanges and substitutions has the advantages of continuing patients' normal enjoyment, offering reasonable substitutes to sustain them in long-term self-care, and providing a degree of control.

81-0715
Compliance From a Patient's Perspective.
Hoover, J.
Diabetes Educator 6(1):9-12, Spring 1980.

Viewing dietary and medication compliance from a diabetic patient's viewpoint reveals that full compliance is not always ideal. The need to behave in a socially or professionally acceptable manner may preclude absolute compliance with prescribed regimens. Admissions resulting from noncompliance with prescribed regimens can afford the patient the benefits of a comfortable hospital stay and the ministrations of an attentive staff. Dietary infractions often result from residence in institutions that offer limited menus or from an inability to afford the diet. Emotional problems associated with obesity, the status of the chronically ill as outcasts, requirements such as urine testing, and guilt over infractions of dietary or treatment regimens further complicate the goal of total compliance. Thus, the patient should not be forced or cajoled into compliance, but given a careful description of the disease and its probable effects. In this way a balance can be struck between the patient's preferences and the physician's requirements.

81-0716
Preoperative Education and the Informed Patient.
Kessler, H. W.
Journal of Legal Medicine 5(10):46-47, October 1977.

The surgical patient's reaction to preoperative education was investigated in a study conducted at the Long Island Jewish-Hillside Medical Center in New Hyde Park, New York. The patient population questioned were (1) over 15 years old, (2) admitted on an elective basis, (3) scheduled for general anesthesia during surgery, and (4) admitted to one of the hospital's general surgery floors. All patients had the opportunity to attend a structured preoperative session that examined preoperative medication, anesthetic administration, awakening in the recovery room, the possibility of postoperative drains or tubes being present in the patient's body, breathing exercises, postoperative pain, medicines, and general postoperative care. Preoperative and postoperative questionnaires were administered, and responses from 68 patients were analyzed. Patients' response to preoperative education was positive; they strongly agreed that their surgeon and associated medical staff were excellent information sources. In addition, patients generally were pleased that several areas of risk-related and anxiety-producing information were not mentioned preoperatively. A closer look at preoperative education and the value of fully informing patients would be helpful in the present medicolegal climate.

81-0717
Systematic Plaque Control in Children Undergoing Long-Term Orthodontic Treatment.
Lundstrom, F.; Hamp, S. -E.; and Nyman, S.
European Journal of Orthodontics 2(1):27-39, 1980.

The effects of systematic plaque control procedures on oral hygiene, caries, and gingival status were studied in 60 schoolchildren, 11-16 years old, from urban and rural school districts in Sweden. Each child required long-term orthodontic treatment with fixed appliances. During the 1.5-month introductory period, each participant received verbal oral hygiene education. At the beginning of active orthodontic treatment, patients were divided randomly into three test groups and one control group. During a 2-year period, test groups received a specific systematic plaque control program based on mechanical or chemical prevention delivered every 3 weeks by a specially trained dental nurse. Control group children rinsed with a placebo solution only. During the retention period of at least 12 months, no prophylactic sessions were scheduled. The final examination was performed 6 months after retention. After the introductory period of intense dental health education, a high level of oral hygiene control was established and maintained, and initial caries and gingival inflammation were minimized. Also, intermittent mouth rinsing with a chlorhexidine digluconate solution as an adjunct to or substitute for mechanical tooth cleaning once every 3 weeks did not further improve oral cleanliness. 30 references.

81-0718
Health Teaching for Recovering Alcoholic Patients.
Marks, V. L.
American Journal of Nursing 80(11):2058-2061, November 1980.

The health education and promotion program for recovering alcoholics at the Brentwood Veterans Administration Hospital in Los Angeles involves 4-6 weeks of inpatient treatment and at least a year of outpatient followup. The staff is composed of nurses, social workers, human service workers, psychologists, secretaries, a part-time physician's assistant, and alcoholism counselors. Teaching materials that complement the other treatment modalities are psychosocial to medical in nature. The program involves formal lectures by the staff, dental service personnel, the hospital chaplain, and dietary department personnel. During early withdrawal, patients are unusually interested in their physical condition. This period is followed by one of ambivalence about the benefits of abstention. After a few weeks of sobriety, interest is shown in basic information concerning normal bodily functions. The educator should listen for underlying concerns in the patient's questions, determine the patient's base-line knowledge and beliefs, aim at an eighth-grade level of literacy, refrain from overloading the patient with details, plan for reinforcement learning, and evaluate program effectiveness. 9 references.

81-0719
Patient Education: Effective Methods in Primary Care Practice.
Marvin, N. G.
Journal of the Kansas Medical Society 81(3):115-117, March 1980.

In the University of Kansas School of Medicine's Department of Family Practice, patient education processes enable the physician to learn from patients, improve communication techniques, and identify the type of information that most effectively accommodates patients' needs. All educational routines are designed to facilitate compliance and improve communication. Six methods are used toward this end: (1) one-to-one dialog between the health care professional and the patient; (2) group

experiences for hypertensive, obstetrical, diabetic, and obese patients; (3) distribution of media materials, made available by organizations concerned with the illness in question; (4) distribution of printed materials, usually given to the patient by a health team member; (5) distribution of audiovisual materials, used in both individual and group situations; and (6) the use of the waiting room, receptionist's desk, lavatory, examination rooms, nurses' station, laboratory, and patient education room in educational routines. The department's experience has shown that (1) time spent with the patient by the health care professional is directly proportional to results; (2) personalized standard written handouts emphasize the personal nature of the instruction; and (3) patients vary in receptiveness to learning techniques, so a variety of strategies should be employed. 7 references.

81-0720
Making Behavioral Objectives Meaningful.
Peters, V. J.
Diabetes Educator 6(3):34-36, Fall 1980.

Properly formulated cognitive, psychomotor, and affective behavior objectives make patient education for diabetics more efficient. Cognitive objectives can be arranged into a hierarchy on the basis of task complexity. In order of complexity, the hierarchy proceeds from rote memorization through comprehension, application, analysis, and synthesis, to evaluation. Cognitive objectives for the diabetic learner could include the ability to list the symptoms of hyperglycemia, explain how the absence of insulin causes hyperglycemia, and describe how hyperglycemia can be prevented if a gastrointestinal illness arises. The psychomotor objectives could include skills associated with drug administration, and urine testing. Affective objectives could involve demonstrating that the patient understands the importance of controlling diabetes and recognizes the necessity of following the medical regimen. When preparing a program outline, the educator can find content for learning objectives in "Guidelines for Program Evaluation," published by the American Association of Diabetes Educators. 7 references.

81-0721
Preparation of the Cardiac Child and the Family for Surgery.
Peterson, M. C.
Issues in Comprehensive Pediatric Nursing 3(7):61-71, December 1979.

Nurses have a unique opportunity to prepare the child and family for the child's cardiac surgery. An initial assessment of the family should include parental guilt, stresses on family members, support from extended family members, the vulnerability of siblings, past experiences with family members who have undergone surgery, the financial burden, and the effects of separation from the home environment. To prepare the parents, the cardiologist should explain the anatomical defect, and the surgeon should explain the procedure, give an estimation of the risk involved, and meet the parents at a postoperative conference in the presence of a nurse. The nurse must prepare parents for the child's appearance after surgery. Use of dolls, films, booklets, and examples from the nurse's experience with cardiac cases can supplement individual and group teaching. In educating and counseling the child, the nurse should consider the child's past experiences, age-associated information needs, and expectations. Explanations by informed parents, use of medical apparatus to familiarize the child with their functions, use of hospital models, and visits to pertinent areas within the hospital can help prepare the child. Finally, play can provide a valuable learning and counseling experience. 8 references.

81-0722
Preparation Play Helps Children in Hospitals.
Schrader, E. S.
AORN Journal 30(2):336, 340-341 August 1979.

The positive effects of preparing children for hospitalization and surgery are discussed. Research has shown that (1) about one-third of hospitals offer some regular preparation in the form of brochures, coloring books, audiovisual materials, dolls and puppets, models and miniatures, or activities; (2) hospitals most likely to offer preparation are those with a recreational or play therapist, a large bed capacity, and a wide range of child admissions; (3) films are more effective than printed materials in reducing anxiety in 3- to 7-year -olds; (4) children prepared for surgery with films showed reduced disturbance at the stress points of anesthesia induction, the blood test, and the immediate postoperative period; (5) 30 minutes of daily therapeutic play with an adult can aid in stress management of hospitalized children; (6) therapeutic play can serve as a diagnostic measure to determine the effects of a child being away from home and the effects of medical treatment; and (7) the use of a scrapbook, diary, or composition about hospitalization, with therapeutic assistance, can help children cope with hospitalization.

81-0723
Contracting With Patients to Improve Compliance.
Steckel, S. B. and Swain, M. A.
Hospitals 51(26):81-82, 84, December 1, 1977.

The use of contingency contracting was examined as a means to increase patient participation in and adherence to hypertension treatment regimens. One hundred and fifty hypertensive outpatients were randomly assigned to one of three groups: routine clinic care, routine clinic care and an educational component with counseling, and contingency contracting as well as routine clinic care and education. Scores for the three groups on an initial hypertension test were not significantly different. Posttest results revealed that providing informative booklets significantly increased patients' knowledge about hypertension and its management. An even greater increase was noted among the contract group. Contracting also significantly influenced continued treatment participation; education and routine care were not an effective means of encouraging treatment continuation. Patients who contracted to lose weight lost a mean of 6.2 pounds, as opposed to no weight loss by patients who did not contract to do so. By the second clinic visit, blood pressures for the contracting group fell below the standard for control and remained there, while blood pressures for the other groups fluctuated considerably. Results demonstrate the effectiveness of reinforcement through contingency contracting. 16 references.

81-0724
Working Model of Patient-Health Education.
Timmreck, T. C.
Radiologic Technology 51(5):629-634, March-April 1980.

A health education model is presented to help allied health care professionals understand the overall ramifications of patient health education. The model has five interdependent components: (1) awareness, which deals with acquiring knowledge about health matters and the ability to appraise individual health; (2) maintenance, which entails the teaching of health care knowledge and the positive role model offered by the health care provider; (3) prevention, in which educators expand their efforts to keep good habits from becoming behaviors that are self-destructive; (4) the change or reduction of already acquired negative health behaviors to positive ones; and (5) presentation of new scientific knowledge to the consumer in a manner that is understandable and that can be incorporated into the lives of those requiring health care services. While motivation is the foundation of health education, more study is needed to learn what motivates individuals and their health-related behaviors. A list of health education aims is presented. 8 references.

81-0725
Genetic Counseling for Psychiatric Patients and Their Families.
Tsuang, M. T.
American Journal of Psychiatry 135(12):1465-1475, December 1978.

An overview of genetic counseling for patients and their families condenses available literature for the benefit of psychiatrists, counselors, and consumers. Topics include (1) the legitimacy of genetic counseling; (2) benefits of counseling; (3) groups that most frequently seek counseling; (4) counseling stages, including diagnosis, determination of family history, estimation of the risk of disorder recurrence, counselee evaluation, establishment of a risk-burden ratio, formation of a plan of action, and followup counseling; (5) methodology used in psychiatric genetic studies; (6) the presence of genetic factors in schizophrenia, affective disorders, presenile dementia, alcoholism, sociopathy, and neuroses; (7) risk elements for the above disorders; and (8) means by which such disorders may be inherited. 101 references.

81P-0726
Northside Hospital Patient Education Program.
Oglesby, S. D.
Northside Hospital Education Department, 1000 Johnson Ferry Road, N. E., Atlanta, GA 30342
Continuing.

The Northside Hospital Patient Education Program is designed to offer prenatal care to pregnant patients and to help patients with diabetes, arthritis, or speech defects cope with their conditions. Although individual programs are provided for patients in each of these categories, the diabetes and prenatal courses are the only programs offered continually. The prenatal program includes a 3-hour general course on pregnancy, a four-session course on childbirth, a six-session exercise course for natural childbirth, and a two-session course on cesarean childbirth. The monthly diabetes class meets on three consecutive nights and 2 weeks after the end of each program for a focus and feedback session. Information on how diabetes affects eyes, teeth, circulation, skin care, and feet is offered through a lecture, discussion, slides, posters and booklets. Staff instructors include a registered nurse, a dietitian, and a physical therapist.

PROFESSIONAL EDUCATION AND TRAINING

81-0727
Dental HE: Using Individual and Community Approaches in Professional Preparation.
Cohen, L.; Silberman, S. L.; Worley, J.; and Runyon, H.
International Journal Of Health Education (Geneva) 23(3):179-188, 1980.

The University of Mississippi School of Dentistry has developed a coordinated 4-year program in health education to enable graduates to function as primary dental health care providers to the community. Program components include (1) basic and advanced problem area course work, in which students demonstrate clinical competencies that are the basis for clinical proficiency examinations given to all junior and senior students; (2) two oral hygiene courses, taught from a problem-solving approach; (3) a course in communication skills training, which provides a model for students to follow in communicating with patients; (4) laboratory sessions, which provide training in the diagnosis, treatment, and prevention of stress-related dental problems, and which allow students to work under faculty supervision with patients during the third and fourth years; (5) a community-based dental health education project, in which the students gain experience in program development and implementation and acquire research skills that enhance previously acquired communication skills; and (6) courses that prepare graduates to offer a range of health education and therapeutic services to many socioeconomic groups. 19 references.

81-0728
Faculty Development in Health Education.
Davidson, M. S.
Upper Montclair, N. J., Montclair State College, Department of Health Professions, 22 p., November 19, 1979. Available from: ERIC; Order No. ED-179 547.

The four major components of preparation programs for college health education faculty are establishment of objectives, evaluation of the faculty, a reward system, and communication and administrative processes. After setting institutional objectives, which are derived from mandates in State law, organizational charter, or other official documentation, departmental objectives should be outlined that focus on the needs of students, the college community, and the surrounding community. Individual objectives should follow from institutional objectives and from those outlined at the departmental level and other subinstitutional levels. Evaluative criteria formulated from these objectives should be set up by the department in conjunction with other institutional units, based on national norms. The evaluation process should address every facet of a professor's academic life. A financial or meritorious reward system should be instituted as a motivational factor. Finally, all members of the academic community should be made aware of all aspects of the program via departmental handbooks, calendars, or newsletters; colloquia; faculty publications; library resource publications; faculty development events; bulletin boards; yearbooks; student meetings; special faculty meetings; and informal exchanges.

81-0729
Survey and Analysis of Educational Efforts in Reproductive Biology and Human Sexuality in American Medical Schools.
Lloyd, J. A. and Steinberger, E.
Journal of Reproductive Medicine 24(1):17-21, January 1980.

Ninety-seven American medical schools responded to a survey of the content of required and elective courses in reproductive biology and human sexuality. A detailed analysis of courses, clerkships, and electives revealed that reproductive biology course content varied considerably, with four times as much emphasis on female-related as male-related subjects. The anatomy, histology, and embryology of the female urogenital tract and the anatomy of the pelvis, perineum, and external genitalia were the most frequently discussed topics. Human sexuality courses were highly individualistic in content compared to reproductive biology courses. The former usually included aspects of heterosexuality and homosexuality, marriage and the family, and premarital and marital counseling. No pattern was found among electives offered in either area. Few topics in reproductive biology and human sexuality were covered by all schools. The discussion of other topics is left to chance, suggesting that the quality of instruction depends upon the availability of instructors qualified to teach in these areas. 3 references.

81-0730
FAO's Activities in Nutrition Education and Training.
McNaughton, J. W.
Food and Nutrition (Roma) 4(1-2):20-24, 1978.

The Food and Agriculture Organization (FAO) nutrition education and training activities consist of assessment of training needs, technical assistance in strengthening nutrition education and training, and preparation of training materials. Six categories of personnel are trained to help developing countries improve nutritional standards, with

priority given to training staff for community-level services. Training is provided through fellowships for training abroad and through inservice programs. In 1961-70, assistance was given to over 60 countries. Regional training activities center on seminars and workshops, national food and nutrition planning, and organization and management of group-feeding programs. FAO has prepared publications, filmstrips, and posters as training materials for use in specific regions or countries. FAO's highest priority is to strengthen nutrition education programs for the needy, particularly the rural poor. 10 references.

81-0731
Training Folk Practitioners as PHWs in Rural India.
Moynihan, M., et al.
International Journal of Health Education (Geneva) 23(3):167-178, 1980.

Folk practitioners in rural India are ordinary villagers who are recognized in the community as having greater knowledge of health and sickness than their neighbors; hence, they treat one or several of 30 illnesses. Four training courses were developed that utilized folk practitioners to provide primary care and health education in (1) treatment of "Nazar," a symptom complex identified in young children and characterized by diarrhea and fever; (2) specialized Nazar cures in another village; (3) childbirth; and (4) skin disease treatment. Training took place in villages and was carried out by doctors in short instructional units followed by discussion, questions, and recapitulation. Neither age, sex, literacy rate, nor caste were barriers to learning. In the first Nazar program, which involved 60 hours of a physician's time in direct teaching, 8 messages were taught and 3 were put into practice by mothers; in the second program, which involved 3 hours of a nonphysician's time in direct teaching, 15 messages were communicated and 3 were put into practice. In the course on skin conditions, 69 percent of drug-related messages and 18 percent of health education messages were put into practice by patients. In the course on childbirth, approximately 22 percent of births in the village were performed using the course teaching. 20 references.

81-0732
Trainer Catalog of Alcohol and Drug Training Materials From the National Center for Alcohol Education and the National Drug Abuse Center.
National Center for Alcohol Education, Arlington, Va. Rockville, Md., National Institute on Alcohol Abuse and Alcoholism (DHEW, ADAMHA) (DHEW Publication No. (ADM)79-834), 192 p., September 1978.
Available from: GPO, Stock No. 017-024-00889-3.

A catalog of training materials for educators offers overviews of alcohol and drug abuse prevention courses offered by the National Center for Alcohol Education and the National Drug Abuse Center.

81-0733
Oral Health Education and Practice (Editorial).
Reade, P. C.
Journal of Oral Pathology (Copenhagen) 8(1):1-2, 1979.

The separation of oral pathology at both the educational and practical level from the mainstream of medical practice has, to some degree, isolated the education of dentists from the rest of medical education. Yet oral practitioners should have the same basic medical education as all other medical practitioners. After this basic education, all future health practitioners, including dentists, should spend time in general medical practice in association with accredited practitioners, and this period should be followed by specialist training in medicine or surgery. In the oral health field, dental hospitals, perhaps in conjunction with other hospitals or groups, could act as the specialist training institutions for oral physicians, oral surgeons, pediatric dentists, and restorative dentists. Clinicians trained by such a system would be provided with a much better health education than at present and could provide better community health service, in terms of both delivery and cost effectiveness.

81-0734
Educating Nurses to Reach Out.
Thornton, E. A.; Layton, P. B.; and Steensland, V.
Nursing Administration Quarterly 4(4):47-60, Summer 1980.

Nursing staff development at Group Health Cooperative of Puget Sound in Seattle, Washington, is examined with respect to (1) ambulatory care services; (2) organization of service departments for outpatient nursing education; (3) provisions for ongoing orientation of new staff members; (4) educational and managerial outcomes of the staff development process; and (5) coordination of staff development in decentralized areas through the use of a centralized resource file. Approximately thirty 1-hour programs are offered each month in the ambulatory setting; most are taught by the nursing staff and other health care professionals, which enables the nurses to share in the teaching and the learning. In addition, nurses use a self-evaluation guide to monitor their own patient-teaching effectiveness. An outline of staff development committees' responsibilities and a photocopy of a patient teaching self-evaluation guide are appended.

81-0735
Teaching Nursing Students to Teach Patients.
Valadez, A. M. and Heusinkveld, K. B.
Journal of Nursing Education 16(4):10-14, April 1977.

Thirty-eight nursing students enrolled at the University of Texas School of Nursing at Houston were offered an elective that centered on the teaching needs of patients with chronic long-term disabilities. The instructors presented a general summary of several learning theories followed by discussions that provided students an opportunity to express their preference for a specific theory. Student performance was evaluated through contractual grading. Requirements for an "A" included an indepth paper on the specific teaching needs of a patient with a long-term disability that could lead to altered body functioning. For a "B" students had to submit three bibliography cards per week on the teaching needs of a specific patient population in relation to altered body functioning. For a "C" students had to submit two bibliography cards per week relating to a general review of the literature on the teaching needs of chronically ill patients. Students rated the course highly. 8 references.

81-0736
A Strategy for Evaluating Nutrition Counseling Skills of Dental Students.
Wittemann, J. K.; DePaolo, D. P.; Modrow, C. L.; and Odom, J. G.
Journal of Nutrition Education 10(4):164-166, October-December 1978.

The 3-year nutrition counseling program at the Medical College of Virginia Dental School is designed to expand and integrate knowledge and skills in the science of human nutrition. Phases I and II deliver basic nutrition information and relate nutrition to the prevention of oral health problems. Phase III focuses on communicating the knowledge acquired in the preceding phases to the patient. Students' counseling skills are developed by using videotape recordings of student interactions with a patient. To evaluate counseling skills, three observer response forms and one student response form were developed. The latter is used to record students' counseling session perceptions and the reactions to nutrition education and counseling as a function of the dentist. Taken with a review of the taped segment, the rating forms reinforce desired behavior and point to areas that need improvement. The forms also help reviewers make a case for repeating the entire counseling session. The most important evaluation outcome has been the training team's realization that student interaction skills are underdeveloped. 13 references.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-0737
Patient Package Inserts and Oral Contraceptives.
Mayberger, H. W. and Bell, B.
Journal of Legal Medicine 5(9):14-17, September 1977.

Recent Food and Drug Administration changes in the regulations covering labeling of oral contraceptives require a brief patient package insert (PPI) and a more detailed PPI to be given to the patient by the dispenser. The PPI covers the effectiveness of this method of contraception, warnings to women over the age of 40 and women with conditions that may be complicated by use of the pill, warnings about possible side effects, and warnings against becoming pregnant immediately after ending use of the pill. The content, tone, and style of the PPI can have a strong effect on the patient's attitude. When dispensing a prescription, the pharmacist should (1) discuss benefits, risks, alternatives, methods of administration, and the right to decline use; (2) invite inquiries; and (3) document that the patient has been informed. Policy questions about contraceptive PPI's are associated with the physician's right to withhold the PPI from a patient, the proper dispenser of the PPI, and the need to include PPI's with intrauterine devices. 7 references.

81-0738
Are Health Services Important to the People's Health?
Morris, J. N.
British Medical Journal (London) 280(6208):167-168, January 19, 1980.

The importance of health services in Great Britain is examined in relation to the premise that the movement for health and prevention through changes in the social system, cultural patterns, and daily living patterns offers the best means to improve health. The British Government has done little in this regard and continues to place the responsibility for change solely on the individual. Recommendations for Government action include (1) statutory food labeling; (2) subsidizing whole-grain products; and (3) making available a low-fat milk to promote reduction of saturated fat intake. Health authorities can encourage people to change their lifestyle, and Government has the responsibility to counter food industry forces; however, the final decision rests with individuals. Although many general practitioners believe that the movement for health and prevention cannot succeed without individual guidance, the primary health care team is uniquely placed to offer such support as part of comprehensive care. 5 references.

81-0739
Health Promotion: A Region VII Special Initiative. A Report of the Ad Hoc Committee for Health Promotion and the Office of the Regional Health Administrator.
Office of the Regional Health Administrator (DHEW, PHS), Kansas City, Mo.
Kansas City, Mo., Public Health Service, 30 p., 1980.

A report prepared by an ad hoc committee of representatives of health promotion organizations is presented. The report includes (1) an identification of both health promotion and direct service needs; (2) a description of five roles for the Region VII Office of Health Promotion based on the synthesis of groups represented; (3) short- and long-term recommendations designed to assist regional health promotion efforts; and (4) responses to the committee recommendations by the Office of the Regional Health Administrator and the Office of Health Promotion, Region VII. Two appendices include findings of the Region VII needs survey and sources of information on preventive health, health protection, and health promotion organizations.

81-0740
Influencing Health Policies: A Case of Not-So-Gentle Persuasion.
Olsen, N.
Nursing Mirror 150(20):18-20, June 26, 1980.

Means by which doctors and nurses in Great Britain can persuade health authorities to introduce health promotion policies are outlined. Politicians have neglected programs that encourage smoking prevention, seatbelt use, water fluoridation, nutritional standards, or drinking and driving regulations. All health professionals should write their Members of Parliament concerning these issues, and health authorities should introduce health promotion policies that encourage smoking cessation among patients with coronary heart disease or chronic bronchitis, and among patients about to undergo elective surgery. Opportunities for low-cost health education include placing of health messages in letters sent from hospitals and health authorities, health promotion advertisements in local newspapers, and role modeling by nurses.

RESEARCH AND EVALUATION

81-0741
Ten-to-Fourteen-Year-Olds and Alcohol; A Developmental Study in the Central Region of Scotland. Volume III.
Aitken, P. P.
Edinburgh, Scottish Health Education Unit, 87 p., 1978.

Behavior and attitudes among 10- to 14-year-old Scottish children regarding alcohol consumption were studied via interviews with 384 children from 8 school districts. Variables examined included peer group influence, parental control, leisure activities, smoking experience, perceived characteristics of children who drink, and judgments of the morality of drinking. Findings reveal that (1) alcohol experience was widespread among subjects; (2) alcohol consumption did not vary with social class or mother's occupation; (3) smoking experience was positively correlated with alcohol consumption; (4) older children made less severe judgments about the morality of children's drinking activities; (5) the extent to which children saw themselves as being influenced by peers increased with age; and (6) children who drank alcohol were perceived in terms of neutrally and negatively evaluated characteristics of extroversion. Research implications for health education are given. 38 references.

81-0742
Evaluation: Obstacles and Potentialities.
Baric, L.
International Journal of Health Education (Geneva) 23(3):142-149, 1980.

Obstacles to evaluating health education activities are examined, including (1) the lack of distinction between research, evaluation, and evaluative research; (2) limited insight into existing behavioral aspects of health problems and their potential solutions; (3) the isolation of health education among specialists; (4) the need to consider individual lifestyle as it influences preventive services and treatment compliance; (5) difficulties in evaluating the achievements of interventions based on theoretical constructs; (6) the lack of reliable indicators to measure the results of community-wide interventions; and (7) differences between short- and long-term intervention effects. A new definition of health education, based on social and personal responsibility and on new models for evaluative research studies, is outlined.

81-0743
The Role of the Occupational Health Nurse in South Africa.
Beaton, G. R. and Pinkney-Atkinson, V.
South African Medical Journal (Cape Town) 56(6):218-220, August 11, 1979.

In August 1978, the Division of Continuing Medical Education of the University of the Witwatersrand, Johannesburg, South Africa, convened a workshop and conference on the role of the occupational health nurse (OHN). Participants were asked to identify specific activities and behaviors that constitute the OHN's role and responsibilities. The OHN's work role is defined in terms of treatment of illness and injury, health supervision of the worker, health education, counseling, occupational safety and environmental monitoring, administration, cooperation and liaison with outside agencies, and continuing professional education and training. Factors that prevent the OHN from achieving full potential include issues related to continued professional education and training; management factors, including expense, ignorance, apathy, and organizational factors; relationships between the OHN and the workers; the work relationship between OHN's and occupational medical officers; issues related to renumeration and motivation; and government policy, including the lack of recognition of occupational health nursing by statutory bodies. Recommendations are offered to remedy each of the above factors. 4 references.

81-0744
Selected Findings on the Impact of the CASPAR Alcohol Education Program on Teacher Training and Curriculum Implementation.
Carifio, J.; Biron, R. M.; and Sullivan, D.
Cambridge, Mass., CASPAR, Inc. (Cambridge and Somerville Program for Alcoholism Rehabilitation), 3 vol. 478 p., February 1978.
Available from: ERIC; Order No. ED-177 169.

The CASPAR (Cambridge and Somerville Program for Alcoholism Rehabilitation) Alcohol Education Program was instituted to (1) train teachers and social service workers to implement alcohol education programs, (2) train selected high school students as peer leaders, and (3) promote community awareness of alcohol-related problems. The CASPAR curriculum was assessed via a sequential cycle evaluation model; the model evaluated the effects of the "Decisions About Drinking" curriculum on students and the effects of training workshops on teachers. Five questionnaires administered to the students measured alcohol knowledge, attitudes, and stereotypes; use and abuse of alcohol; prior exposure to alcohol education; social desirability of alcohol use; and satisfaction with the CASPAR teaching session. Teachers completed a knowledge and attitude questionnaire and a process log. Findings are reported in detail.

81-0745
Factors for Improved Genetic Counseling for Retinoblastoma Based on a Survey of 55 Families.
Carlson, E. A.; Letson, R. D.; Ramsay, N. K. C.; and Desnick, R. J.
American Journal of Ophthalmology 87(4):449-459, April 1979.

A survey is presented that reveals inheritance patterns and other characteristics of families in which one or more members were treated after 1960 for retinoblastoma at the University of Minnesota Medical Center. Of 55 families treated, 5 involved more than 1 patient. Two of the five family cases involved collateral inheritance and three involved direct inheritance. Factors important for genetic counseling include the time of onset of first symptoms, the father's age, the occurrence of a second primary tumor, unilateral versus bilateral involvement, and the cytogenic analysis of the patient's chromosomes. Additionally, mutational mosaicism was considered as a cause for sporadic cases. Five genetic counseling categories for retinoblastoma are summarized, and pertinent risk figures are provided. 22 references.

81-0746
Information and Participation Preferences Among Cancer Patients.
Cassileth, B. R.; Zupkis, R. V.; Sutton-Smith, K.; and March, V.
Annals of Internal Medicine 92(6):832-836, June 1980.

To determine the degree to which cancer patients seek information and medical care, 256 cancer patients completed the Information Styles Questionnaire and the Beck Hopelessness Scale. Patients' behaviors and beliefs exemplified the contemporary standard of informed and active involvement; younger patients conformed more closely to the well-informed standard of patient behavior, whereas older patients preferred the older, nonparticipatory patient role. Patients seeking involvement in treatment decisions were significantly more hopeful than those who did not. However, most patients in each age group displayed high levels of hope, preferred open communication about their illness, and desired maximum amounts of information. High patient hope levels are viewed as manifestations of denial. 20 references.

81-0747
Effects of Childbirth Preparation.
Cogan, R.
Clinical Obstetrics and Gynecology 23(1):1-14, March 1980.

A review of the literature on childbirth preparation classes leads to several conclusions. First, childbirth preparation is often elected by women who are well educated and affluent; their husbands are more likely to participate in the childbirth experience than are other husbands. Second, positive experiences of childbirth often resulted from preparation, and such experiences have occurred even when motivation for class attendance has been carefully controlled. Demonstrated positive effects have included (1) medication reduction during parturition; (2) reduced pain during labor and pregnancy; (3) less frequent use of forceps; and (4) a more positive attitude toward the experience of labor and delivery following birth. Based on these positive effects, childbirth education should be integrated into prenatal health care for all women and can offer a preventive health care tool for women from low-income groups. 38 references.

81-0748
The Need to Assess the Impact of Death Education.
Crase, D.
Death Education 1(4):423-431, 1978.

Formal approaches to death education and to the assessment of death education programs are needed. In 1974, it was estimated that over 1,000 thanatology courses were being offered in higher education institutions. Nevertheless, few reports have been published that review evaluations of these courses. An area that needs particular attention is the attitudes of students who enroll in thanatology courses and the attitudes of the teachers. The relationship between death education and suicide rates among students needs to be examined. Evaluation efforts have been hindered by lack of rigor in design, small sample populations, and inadequate instrumentation. The Thurstone Equal Appearing Interval Attitude Scale was used successfully in 1975 to evaluate the effect of a thanatology course on a sample population of 692 students. Results of these and other well-designed studies indicate that demographic characteristics and recent experiences with death have little effect on student attitudes toward death; that teacher qualifications, the level at which a course is taught, and course objectives bear on course efficacy; that behavioral and attitudinal outcomes should receive careful attention; and that anxiety over death and dying tends to be relieved by the courses. 22 references.

81-0749
Dimensions of Children's Health Beliefs.
Dielman, T. E.; Leech, S. L.; Becker, M. H.; Rosenstock, I. M.; Horvath, W. J.; and Radius, S. M.
Health Education Quarterly 7(3):219-238, Fall 1980.

Interviews were conducted with 250 children 6-17 years old to examine the origin and development of health beliefs. Each series of questions was grouped according to the health concerns of the children, including (1) specific health concerns, (2) general health concerns, (3) perceived parental concern, (4) perceived general susceptibility, (5) perceived susceptibility to specific conditions, and (6) perceived seriousness of and susceptibility to disease. Findings on the intercorrelation among the six primary groupings are presented, as well as age and sex groupings. No significant sex differences or sex by age interaction effects were noted. Younger children scored significantly higher on perceived parental concern and concern about health in general. In every instance where significant differences occurred between age groups, the youngest group showed the greatest variance. Results provide partial support for a model of children's health beliefs and a basis for further use of concepts central to an understanding of motivated health behavior. Implications for practice are examined. 27 references.

81-0750
Evaluation of an Oral Hygiene Program for Preschool Children.
Friedman, L. A. and French, C. I.
Journal of Preventive Dentistry 5(6):14-15, 18, November-December 1978.

A study was conducted to (1) determine the feasibility of evaluating personal oral hygiene performance in preschool children; (2) establish oral hygiene proficiency among this population; (3) determine preschool children's ability to learn personal oral hygiene skills; and (4) determine preschool children's ability to practice these skills after school supervision was discontinued. Children 3-5 years old who were enrolled at one of two day care centers served as subjects. The treatment regimen was a crossover design in which each school served as a control group for the other during the 3-week treatment phase. The program consisted of toothbrushing demonstrations and supervised daily toothbrushing. Weekly examinations were performed for 6 weeks, beginning 1 week after program implementation. A final dental examination was made 1 month after program termination at one of the centers. Findings revealed that (1) personal oral hygiene performance of preschool children could be evaluated; (2) subjects demonstrated unsatisfactory oral hygiene profi-

ciency, but were capable of learning such skills; (3) differences in educational structure and facilities affected neither the child's ability to learn and practice skills nor the dental health consultant's ability to supervise toothbrushing; (4) subjects did not continue to practice learned skills at home; and (5) professional supervision was more effective than teacher supervision.

81-0751
An Experimental Evaluation of the KAP Model for HE.
Hamilton, N. E.; Belzer, E. G.; and Thiebaux, H. J.
International Journal of Health Education (Geneva) 23(3):156-161, 1980.

An experimental program on breast cancer was designed according to the KAP (knowledge of, attitude towards, and practice of a particular behavior) model. The program was a 35-minute audiovisual presentation consisting of 80 slide-tape messages. Eighty-eight women, 19-80 years old, served as subjects and were randomly assigned to four groups. A control group was given an educational program on an unrelated topic, while the experimental groups received the program in one of three formats: without questions, with preprogram questions, or with postprogram questions. Subjects were evaluated via a booklet administered immediately after the program, and a questionnaire administered 2 months after program presentation. Analysis of the data revealed that all three groups of experimental subjects knew significantly more about breast cancer than control subjects, and that 82 percent of experimental subjects practiced breast self-examination during the 2-month followup period, as compared to 60 percent of the control group. No significant differences were found between the knowledge scores of subjects presented with questions and those who did not receive such questions. Results provide evidence of the KAP model's validity and illustrate that programs developed according to the model can have powerful results. 6 references.

81-0752
"Healthy People": Critique of the Nutrition Segments of the Surgeon General's Report on Health Promotion and Disease Prevention.
Harper, A. E.
American Journal of Clinical Nutrition 33(7):1703-1712, July 1980.

Although "Healthy People" provides information on the state of health in the United States and identifies the major health problems of different age groups, the author feels "Healthy People" fails to acknowledge that present lifestyles, however unhealthy, permit people to live more than 70 years and fails to acknowledge the need for a comprehensive medical care program, despite citing the importance of greater access to medical care. According to the author, the analyses of infant and maternal nutrition, dental health, obesity, hypertension, diet and cancer, and nutrition of the elderly are more objective and critical than those in the chapter on health promotion, a section of which deals specifically with nutrition. Some recommendations in the nutrition section are not supported by analyses given in other sections. There is no indication that a qualified group of nutrition scientists prepared or reviewed the nutrition sections. Overall, the report seems to be a Department of Health, Education, and Welfare suggestion that lower health care expenditures can be accomplished by shifting funds toward prevention-oriented programs. In the past, successful preventive programs have also been accompanied by increases in health care costs. Questions concerning the economic implications of a comprehensive preventive health care program are raised. 23 references.

81-0753
Look at It This Way: Some Aspects of the Drug Mix-Up Problem Among Black, Poor, Aged, and Female Patients.
Johnson, E. F.
Journal of the National Medical Association 70(10):745-747, October 1978.

The use of nonprescription drugs among black, poor, aged, and female patients to relieve psychological and emotional difficulties is examined. Because of the ready availability of such drugs as sleeping pills, weight control pills, and vitamins, individuals can purchase advertised medication without physician supervision. Ignorance of the cumulative impact of mixing medications often leads to addiction and side effects. To prevent drug abuse, requirements for more readable labeling of patient medicine, research concerning drug interactions with food and alcohol, and increased doctor-patient communication concerning drug prescriptions are needed. A humanistic approach toward understanding the drug interaction problem among population groups is required and would consider basic needs and coping patterns.

81-0754
Consumers Must Become Partners in Their Own Care.
Meyer, L.
Hospitals 51(7):79-80, 82, April 1, 1977.

A review of health education literature published in 1976 is presented. Topics include (1) the need for a cooperative wellness strategy, in which hospital administrators and health planners help area residents to achieve better health by working as partners in the common project; (2) the creation of the National Center for Health Education to examine educational needs in the workplace, broaden communication lines between patients and health experts, and determine the scope of health education needs at the Federal, State, and local levels; (3) the need to identify successful health education programs that are capable of being institutionalized or adapted elsewhere; and (4) the increasing importance of self-care. 23 references.

81-0755
Long-Term Management of Hypertension: II. Private Practice Experience.
Moser, M.; Grellet, C.; Okin, P.; Hodas, A.; Hamill, E.; and Rudick, J.
New York State Journal of Medicine 80(7 Pt 1):1102-1106, June 1980.

To determine the level of blood pressure control in the private practices of six physicians, 7,788 patient charts were reviewed regarding (1) specific diagnostic evaluation, (2) degree of blood pressure lowering achieved, and (3) frequency of visits and their influence on blood pressure control. Adequate blood pressure control was defined as an average diastolic blood pressure below 90mm Hg for the last three readings. Findings revealed that (1) 20.6 percent of patients were hypertensive; (2) 89.3 percent of these patients were on active hypertensive drug therapy; (3) 54.2 percent of patients achieved blood pressure control within 6 months of therapy; and (4) control was achieved significantly more often in patients who were seen four-six times in the first 6 months, than in those who were seen one-three times. An analysis of patient care costs conducted over a 1-year period on a series of patients from one practice revealed that the cost was equal or less than that of public health care services. 13 references.

81-0756
The Future of Allied Health Education: New Alliances for the 1980s.
National Commission on Allied Health Education, Washington, D.C.
San Francisco, Calif., Jossey-Bass, 280 p., 1980.

An overview of the allied health field and the role of the occupations in the field is presented. Topics include the allied health concept in the next decade, current status of allied health occupations and manpower considerations, the outlook for allied health careers, the scope and diversity of allied health education, collaboration between educational institutions, collaboration between disciplines, means of strenghtening alliances in service and education, and means of determining appropriate content and level of educational programs. Also discussed are means of improving clinical education, means of building the capability for leadership and innovation, means of planning and administering diverse programs without waste, means of obtaining funding, and the impact of educational alliances on health. Appendices include an inventory of health occupation education programs in 2- and 4-year colleges and universities, and a discussion of the Carnegie Classification of Higher Education Institutions is appended. Numerous references.

81-0757
What Encourages and Discourages Children to Smoke? Knowledge About Health Hazards and Recommendations for Health Education.
Nye, P. A.; Haye, K. L.; McKenzie-Pollock, D. J. B.; Caughley, B. L.; and Housham, R. W.
New Zealand Medical Journal (Dunedin) 91(661):432-435, June 11, 1980.

Knowledge about the dangers of smoking and factors that encourage or discourage smoking were examined by using a confidential questionnaire administered to 191 New Zealand high school students. Findings revealed that 39 percent of the sample were smoking, 42 percent had tried and given up, and 19 percent had never tried smoking. Students' smoking habits were related to the smoking habits of their friends, but not their parents. The average number of diseases the students attributed to smoking was 2.5, and most associated cancer with smoking; however, 18 percent incorrectly associated certain diseases with smoking. Fifty-seven percent tried their first cigarette out of curiosity, and 71 percent smoked regularly out of desire to "be tough" or "impress others." Boys experimented earlier than girls. Subjects were most discouraged from smoking by the health risks and saw demonstration of harmful effects and increased health education as the best means to discourage others. Suggestions for improving health education are given. 16 references.

81-0758
An Objective Measure of the Validity of Children's Responses to a Questionnaire on Health and Smoking.
Pederson, L.; Sidney, K.; and Lefcoe, N. M.
Canadian Journal of Public Health (Ottawa) 68(6):497-498, November-December 1977.

A long-term smoking awareness program using 3,000 children in grades 4-6 is designed to develop proper attitudes toward smoking and to educate children about the relationship between smoking and disease before the habit is established. Since questionnaires measuring children's attitudes, knowledge, and behavior with regard to smoking are valid only if the responses are truthful, the validity of responses was assessed in a subsample of 130 children, using a measure of carbon monoxide concentration in expired air. It was determined that 5.5 percent of the children reported that they were nonsmokers when their carbon monoxide measurement indicated that they had smoked recently. It was concluded that most responses children gave about smoking behavior were truthful. An evaluation of the long-term program is in progress. 9 references.

81-0759
44-Year Dental Health Survey of Helsinki Schoolchildren.
Rytomaa, I.; Jarvinen, V.; and Calonius, P. -E. B.
Community Dentistry and Oral Epidemiology (Copenhagen) 8(1):66-67, February 1980.

Changes in the number of intact teeth in 7- to 13-year-old Helsinki, Finland, schoolchildren from 1934 to 1978 were studied to determine if changes were correlated with the reduction of sugar consumption during World War II and with later Finnish dental health education programs. The materials examined consisted of student records and patient charts randomly selected from the central dental registry for Helsinki schoolchildren. Results revealed that the number of intact teeth increased during, and for some years after, the war and then decreased again. These changes were seen both in incisors and in first molars. The number of intact molars began to increase in the early 1960's, when the first attempts were made to improve dental health through education. After 1972, a more general increase in the number of intact teeth occurred. However, in the 13-year-old group, the number of intact first molars has increased only slightly. Results demonstrate the effectiveness of dental health education in prevention of caries. 6 references.

81-0760
Rural Adolescent Fertility, Its Place Among Child Health Problems.
Sudiyanto
Paediatrica Indonesiana (Djakarta) 19(11-12):313-322, November-December 1979.

Issues associated with rural adolescent fertility in Indonesia are examined. Topics include (1) medical risks of early pregnancy; (2) demographic and social consequences of early childbearing; (3) delivery of family planning services; (4) a listing of child health problems including communicable diseases, diseases preventable through immunization, diseases transmitted through direct contact, conditions related to food and nutritional problems, and conditions related to human reproduction. Family planning programs are needed that encourage development of positive attitudes towards sexual behavior; teach reproductive physiology; inform adolescents about early pregnancy risks; encourage contraceptive use; and provide information on the availability of contraception and abortion services. Major obstacles to school-based sex education programs are listed, and recommendations for government involvement in disseminating family planning information are given. 6 references.

81-0761
Effect of Dental Health Care Instruction and Prophylaxis on Knowledge, Attitude and Behavior in Dutch Military Personnel.
Tan, H. H.
Community Dentistry and Oral Epidemiology 7(5):252-258, October 1979.

To evaluate the effect of a single dental health care instruction and prophylaxis on knowledge, attitude, and behavior, 96 army recruits from two camps were randomly assigned to one of four groups: control; oral prophylaxis; dental health care instruction; or prophylaxis and instruction. Dental knowledge and attitude toward dental health were measured by questionnaires at 1 and 3 months following treatment. Results revealed that both single group instruction and instruction plus prophylaxis significantly improved knowledge and improved attitude slightly, but did not improve behavior except for relatively new instruction areas. Results are consistent with previous observations that dental health knowledge is more advanced than its practice. Results also indicate that knowledge should be reinforced within a month. However, it was unclear which factors in the single instruction were most responsible for the obtained effects. Results suggest that research specially designed to explore the process leading to behavior change is needed, rather than research measuring only the effect of dental health care instruction. 15 references.

RISK REDUCTION

81-0762
Your Innate Asset for Combating Stress.
Benson, H.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 12 p., (197-).

A basic technique for eliciting the relaxation response is provided for the business executive. Four basic elements are essential to the technique: (1) a quiet environment with few distractions; (2) employment by the subject of a single-syllable sound or word to free the subject from logical, externally oriented thought; (3) a passive attitude by the subject; and (4) a comfortable position to reduce muscular effort. Upon learning the technique, subjects generally report feelings of relaxation and freedom from anxiety, which last throughout the day. Research findings on the use of relaxation to treat hypertension, alcoholism, and drug abuse are presented, and the benefits of relaxation response for the business community are summarized.

81-0763
Mass Media, Self-Management, and Smoking Modification.
Best, J. A.
In: Behavioral Medicine: Changing Health Lifestyles. Davidson, P. O. and Davidson, S. M., eds. New York, Brunner-Mazel, p. 371-390, 1980.

The effectiveness of a comprehensive antismoking self-management program with a television and print format was evaluated by using a sample of 1,403 persons. Each television show broadcast in Bellingham, Washington, was linked to a specific chapter in a self-help guide. The first show and chapter provided an introduction to the program and called for an explicit decision to quit. Behavioral change strategies were introduced in the second session. For the final three sessions, smoking urges were analyzed via a problem-solving technique. Participants were assessed through questionnaires administered before the first session, immediately after the last session, and at 3- and 6-month intervals after program completion. Results revealed that long-term smoking abstinence occurred in approximately 20 percent of participants. Demographic variables such as age, sex, education, and smoking history were not outcome predictors. Successful subjects tended to smoke less initially and to smoke lower nicotine cigarettes. A high incidence of relapse was associated with stress. Recommendations for future research strategies are given. 60 references.

81-0764
Parents' Evaluations of Genetic Counselling.
Black, R. B.
Patient Counselling and Health Education 2(3):142-146, 1980.

To better understand individuals' reactions to genetic counseling, 26 families who had one mentally retarded child under 7 years of age were divided into 2 groups and interviewed over a 1-year period. In the first group, the child was diagnosed as having Down's syndrome, and in the second group, the child was diagnosed as having mental retardation of unknown etiology. Although families in both groups had similar social characteristics, parents in the first group were slightly older. In their comments, parents stressed the need for more time and individual attention from genetic counselors, additional followup and supportive counseling, and increased efforts to educate the general public about birth defects. Findings underscored the anxiety that can be generated in parents during counseling. The use of strange medical terminology, hurried sessions, and presentations before large groups further heightened anxiety. Implications for developing and improving genetic counseling services are examined. 16 references.

81-0765
Coronary Disease Prevention: Practical Approaches to Risk Factor Changes.
Blackburn, H.
Advances in Cardiology (Basel) 20:1-9, 1977.

Concepts necessary for coronary heart disease prevention are examined. Topics include (1) the need for physicians to emphasize a prudent diet, diastolic blood pressure reduction, moderate exercise, and long-term weight control; (2) guidelines for disease prevention through proper health habits and reduction of risk characteristics; (3) base-line measurement and evaluation of major elements of coronary risk; (4) the reduction of serum cholesterol levels through decreased intake of red meat and meat products, dairy products, eggs, and fats and oils; (5) the relationship between physical activity and body weight; and (6) selection of smoking cessation methods. 6 references.

81-0766
The Primary Prevention of Atherosclerosis in General Practice.
Campbell, I. K.
Journal of the Royal College of General Practitioners 28(192):407-413, July 1978.

Evidence for and against various risk factors in the pathogenesis of atherosclerosis are reviewed, and medical and public attitudes towards the preventive measures of screening and health education are examined. Risk factors investigated include cigarette smoking; hypertension; hyperlipoproteinemia; physical activity; obesity; family history; personality, stress, and behavior; diabetes; hyperuricemia; and the relative importance and additive action of risk factors. Aspects of risk factor screening and health education examined include screening rationale; the pros and cons of screening and health education; the acceptability and effectiveness of screening and education; an interdisciplinary approach to screening and education; the use of community nurses, health visitors, and practice nurses; the organization of screening and health educators; the integration of screening and education with specialized clinics; and community- and industry-based health education. Education and screening have greater potential for decreasing morbidity and mortality than treating established disease, and both can be carried out by nurses or health visitors. 32 references.

81-0767
Promoting Health: Prospects for Better Health Throughout Australia.
Commonwealth Dept. of Health, Canberra (Australia).
Canberra, Australian Government Publishing Service, 66 p., May 1979.

The world debate over health promotion is likely to have far-reaching effects on the future of health care in Australia. Recent attacks on the "medicalization of life" have resulted in a demand within the medical profession for research and technological advancement in prevention. Existing knowledge can be applied to health promotion efforts of the public health movement, communities, schools, legislators, physicians, consultants, hospitals, industry, and self-help groups. Questions are likely to arise concerning identification of target populations, reformation of the social and economic environments, implementation of a food quality policy, cost effectiveness in preventive medicine, implementation of incentives and sanctions within health insurance policies, creation of a consumer health index, definitions of health, government intervention in the lives of individuals, and the status of health as a right or an obligation. 112 references.

81-0768
Dental Health Education Behind Bars.
Cutler, J.
Dental Assistant 48(1):16-19, January-February 1979.

In January 1976, the Nashville Dental Assistants Society began an intensive dental health education program for residents of the Tennessee Prison for Women in Nashville. Following an orientation session for dental assistants and the development of mechanisms to promote inmate interest and involvement, a public health dentist examined 52 volunteers in a screening clinic. Participants were then rated according to their need for participation and scheduled for three weekly workshops. Five to seven inmates and one dental assistant participated in each session. The first session dealt primarily with proper dental skills, such as brushing and flossing, and was instructor oriented. In the second session, participants viewed a preventive dentistry film and reviewed dental diseases and their causes, plaque, the role of foods such as sugar, and the value of self-care. In the final session, skills and information from the first two sessions were reviewed, and the instructor attempted, on an informal basis, to help participants isolate reasons for exhibiting improper dental health care. Thirty-five women completed the workshops, a significant number compared with participation in other voluntary programs. All participants demonstrated proficiency in brushing and flossing and expressed some understanding of dental health facts.

81-0769
The Connecticut High Blood Pressure Program: A Program of Public Education and High Blood Pressure Screening.
D'Atri, D. A.; Fitzgerald, E. F.; Freeman, D. H., Jr.; Vitale, J. N.; and Ostfeld, A. M.
Preventive Medicine 9(1):91-107, January 1980.

The Connecticut High Blood Pressure Program (CHBP) conducted parallel programs of public education and screening at multiple sites throughout the State. In 1974-76, 189,006 adults were screened, of whom 68,240 were classified as hypertensive. The proportion was higher than the estimate obtained by the National Health Survey, but can be explained by the age structure and treatment status of the CHBP sample. Industries and educational institutions were the most successful sites in terms of proportion of eligible people participating to people who consequently received medical care. Of those screened as hypertensive and previously unaware of or untreated for the condition, 53 percent contacted a physician, were diagnosed as hypertensive, were placed on treatment or under surveillance, and complied with the therapeutic regimen for at least 4 months. Among hypertensives 45-69 years old, awareness and adequacy of treatment increased from 1974 to 1976. Older people, women, and blacks in this group were the most likely to be aware of their condition and to be adequately treated. The public health implica-

tions of these findings and their usefulness in planning and guiding other screening programs are discussed. 27 references.

81-0770
Area Wide Nutritional Support Service.
Dean, R. E.
JPEN. Journal of Parenteral and Enteral Nutrition 1(2):105-107, 1977.

An Area Wide Nutrition Team, consisting of physicians, nurses, dietitians, and pharmacists, was established on the Grand Rapids campus of Michigan State University to improve the quality of nutritional care for hospitalized patients, provide educational programs for health care professionals, and establish communication links with medical and academic personnel involved in regional nutrition efforts. Team activities have included (1) implementation of a continuing medical education symposium entitled "New Concepts in Nutrition"; (2) development of a model nutrition support service at a medical center hospital, which provides consultation, directs the management of patients on hyperalimentation and elemental diets, conducts clinical studies, and ensures quality nutrition of nutritionally depleted patients; (3) outreach educational programs for medical and paramedical personnel that focus on general nutritional areas; (4) dissemination of practical nutrition information throughout the hospital; and (5) participation in a cancer outreach program focusing on nutrition as a cancer care component. 2 references.

81-0771
Is Education Not Enough?
Guthrie, H. A.
Journal of Nutrition Education 10(2):57-58, April-June 1978.

The Society of Nutrition Education is committed to programs that disseminate information on sound nutrition practices. Despite increased public interest in nutrition, many who are well informed retain faulty dietary habits, and misinformation sometimes influences diet more than accurate information. Nutrition educators should consider that (1) information is often not enough to cause or enable individual improvements in eating habits; (2) the benefits of improved nutrition habits are delayed in the case of weight reduction or are indirectly experienced in averted ilinesses; (3) it is difficult to offer sound nutritional alternatives to the conflicting and often highly emotional claims that immediate benefits can be achieved from specific foods or food patterns; and (4) variety in food selection needs emphasis, and such variety is possible even when taking into account the tastes of ethnic, economic, geographic, or age groups. 3 references.

81-0772
Disease Prevention in Youth: Setting the Stage for the Long Term.
Hamburg, D.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 19 p., (197-).

The need for a significant shift in health policy toward disease prevention in youth is examined. Subjects include (1) underutilization of proven vaccines for polio and measles and other preventive measures; (2) the need to approach heavy cigarette smoking in early adolescence, when the habit begins; (3) the relationship between (a) reductions in smoking and dietary fat intake and (b) education; (4) the per capita rise in smoking among adolescents 10-15 years old, especially females; (5) the need for physicians to focus on communicating with adolescents; (6) advances in biological, behavioral, clinical, and epidemiological research that help clarify the transition from childhood to adulthood; (7) the media's impact on adolescent health behavior; and (8) positive developments in adolescent health education, such as peer counseling, smoking cessation programs, public health disc jockeys, and programs for adolescents at academic health centers.

81-0773
The Air We Breathe and Its Role in the Prevention of Disease.
Mitchell, R. S.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 20 p., (197-).

The text of a slide presentation on air pollutants and possible solutions to the air pollution problem, particularly in Colorado, is presented. Topics include airborne poisons; urban air pollutants; air pollution disasters; the reduction of automobile emissions through gasoline rationing, engine modification, and regular emission inspections; premature deaths from cigarette smoking; presumed causes of lung cancer; emphysema; smoking and nervousness; per capita cigarette consumption; the ventilated cigarette; the filtered cigarette; cigarette advertising claims; smoking cessation methods; and the need to review and test market promising smoking curtailment initiatives. 5 references.

81-0774
The Whole College Catalog About Drinking: A Guide to Alcohol Abuse Prevention.
National Clearinghouse for Alcohol Information (DHEW, ADAMHA), Rockville, Md.
Rockville, Md., National Institute on Alcohol Abuse and

Alcoholism (DHEW Publication No. (ADM) 77-361), 129 p., 1977.
Available from: GPO; Stock No. 017-024-00515-1.

A guide is presented to encourage fresh thinking and experimentation regarding alcohol abuse prevention. Topics include (1) the need for prevention work at the college level, (2) basic facts about the workings and effects of alcohol, (3) developmental stages of a campus-based alcohol education program, (4) program strategies based on both specific and nonspecific personal development and environmental change, and (5) brief summaries of programs developed on different campuses. Lists of available training programs and courses, media materials, alcohol facts and ideas, party recipes, and references and resources are appended. 21 references.

81-0775
Statistical Design Considerations in the NHLI Multiple Risk Factor Intervention Trial (MRFIT).
National Heart and Lung Inst. (DHEW, NIH), Bethesda, Md. Multiple Risk Factor Intervention Trial Group.
Journal of Chronic Diseases 30(5):261-275, May 1977.

Statistical aspects of the National Heart and Lung Institute's Multiple Risk Factor Intervention Trial (MRFIT) design are presented. The trial was undertaken in 1976 to determine the efficacy of intervention trials with individuals at high risk of coronary heart disease due to combinations of elevated serum lipids, hypertension, and cigarette smoking. Topics include (1) the method of assessing overall risk; (2) use of Framingham study data to estimate risk assessment parameters; (3) the assumptions upon which statistical computations of sample size and power were based; (4) the procedure used to estimate anticipated individual risk reduction, as well as procedural imperfections; (5) the selection procedure qualifying individuals for entrance into the trial, and means to monitor the procedures' effectiveness; (6) the potential for isolating effects of each intervention modality; (7) discrepancies between design assumptions and trial realities; and (8) potential uses of the risk function approach for trial monitoring. An appendix examines the methodology for adjusting sample size computations. 10 references.

81-0776
America's Immunization Nears 90 Percent Goal. Pharmacists Help in Public Education.
Small, W. E.
American Pharmacy 19(11):23-24, October 1979.

Since 1976, the American Pharmaceutical Association has urged its members to join the national immunization campaign promoted by the U.S Department of Health, Education, and Welfare in response to an increase in reported cases of communicable diseases. According to the U.S. Public Health Service (PHS), laws in all 50 States require immunization as a condition of entry into schools. With a few exceptions, vaccinations are required for polio, measles, mumps, rubella, diphtheria, tetanus, and pertussis. Diphtheria, tetanus, polio, and pertussis have almost been eradicated, according to PHS. Child-by-child assessments of schoolchildren in 44 States and most territories show that children 5-14 years old have more than a 90 percent immunization rate in diphtheria, tetanus, pertussis, measles, and polio, and 84 percent in rubella. An Academy of Pharmaceutical Sciences task force is investigating a rabies vaccine being produced from human diploid cells and is also studying the major issues regarding mass immunization for influenza, typhoid, and pneumococcal pneumonia among the elderly.

81-0777
Prevention and Control of Hypertension by Nutritional-Hygienic Means. Long-Term Experience of the Chicago Coronary Prevention Evaluation Program.
Stamler, J.; Farinaro, E.; Mojonnier, L. M.; Hall, Y.; Moss, D.; and Stamler, R.
Journal of the American Medical Association 243(18):1819-1823, May 8, 1980.

Long-term findings of the Chicago Coronary Prevention Evaluation Program (CPEP), which sought by nutritional and hygienic means to control multiple risk factors for atherosclerotic disease in coronary-prone men, are presented. Five hundred and nineteen men, 40-59 years old, participated over a 15-year period. One hundred and fifteen had mild hypertension at entry, and another 101 had high-normal diastolic blood pressure (BP). The CPEP regimen achieved moderate weight loss, reduced pulse rate, and reduced serum cholesterol levels. Sustained falls in BP were recorded, resulting in long-term BP normalization. Changes in weight and BP were significantly correlated. Long-term improvements in eating and exercise habits, yielding moderate sustained weight loss, were useful in preventing high BP in hypertension-prone persons and in controlling established mild hypertension. 20 references.

81-0778
Community Programme for Control of Hypertension in North Karelia, Finland.
Tuomilehto, J.; Nissinen, A.; Salonen, J. T.; Kottke, T. E.; and Puska, P.
Lancet (London) 2(8200):900-903, October 25, 1980.

A community-based program to improve awareness and control of hypertension was launched in 1972 in North Karelia, Finland. Objectives included (1) locating as many hypertensives as possible; (2) controlling blood pressure in these patients; (3) establishing uniform diagnostic and therapeutic methods among physicians; and (4) gathering information about the epidemiology of hypertension and the function of health services. The program was integrated into the existing health care structure and authorized by the health care authorities. Special hypertension clinics were established in local health centers and supervised by public health nurses. In spring 1972, a base-line study was conducted in North Karelia and in a matched reference area; a final survey was carried out in both areas in 1977. Results from the 1977 survey revealed that, compared with the reference area, awareness of hypertension had improved, the prevalence of hypertension had decreased, blood pressure levels were lower by age group, and the number of persons receiving treatment for hypertension had increased. Since the program had been integrated into available health care structures, the greatest expenditure was medication, followed by personnel. Results suggest that a systematic approach and appropriate health education can facilitate cooperation with hard-to-reach population groups. 22 references.

81-0779
Nutrition and Its Role in Prevention of Disease.
Winikoff, B.
In: New Directions in Health. (Conference Held) October 4-7, 1978, Keystone Conference Center, Keystone, Colorado. Denver, Colo., Gates Foundation, 26 p., (197-).

The relationship between nutrition and disease prevention in the American diet was examined in a slide-show format. Topics included (1) changes in nutrient consumption since World War II, exemplified by an increase in fat, carbohydrate, animal protein, and salt consumption, coupled with less consumption of crude fiber; (2) an increase in consumption of food prepared by industrial processes, which are poorly understood by the consumer; (3) changes in disease patterns as a result of diet; (4) recommendations for change based on the pamphlet "Dietary Goals for the United States"; (5) public and private nutrition interventions; and (6) design of appropriate interventions based on sources of food purchases and influences on food choices. Needed changes in the scope and emphasis of current nutrition education are discussed. 2 references.

81-0780
Alcoholics Anonymous and the Treatment and Prevention of Alcoholism.
Zinberg, N. E.
Alcoholism: Clinical and Experimental Research 1(1):91-102, January 1977.

An overview of the principles of Alcoholics Anonymous (AA) is presented to show that these principles are aimed at treatment of hard-core alcoholics and may not support or may even be opposed to prevention principles. The AA viewpoint towards the following emotions and tendencies is examined: (1) the alcoholic's denial of alcoholism; (2) the need for personal relationships that avoid total dependency on a particular person; (3) the alcoholic's phobias of drunkenness and sobriety; and (4) the tendency to judge alcoholics harshly. A resurgence of scientific interest in alcoholism is needed and will involve a commitment to teaching, training, and research by organized medicine, psychiatry, and other professional groups involved with drug dependency. In addition, greater consideration of controlled alcohol use is necessary. Professionals can learn from AA, but should resist any tendency toward a dogmatic acceptance of AA's more doctrinaire tenets. 31 references.

81P-0781
Health Plus.
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Palm Beach County Health Department, 826 Evernia Street, West Palm Beach, FL 33402
Funding Source: Florida State Dept. of Health and Rehabilitative Services, Tallahassee.
1979 - Continuing.

The Health Plus program is designed to help Palm Beach County residents identify and reduce risk factors such as smoking, obesity, inactivity, diabetes, and high blood pressure. The program offers computer-analyzed health hazard appraisals, blood tests, instruction in relaxation methods, counseling for behavior change via a contracting technique, and group support for behavior change. Staff members also refer clients to physicians or community programs for weight control, smoking cessation, and stress management. The staff is also active in identifying these programs and, if there are gaps, promoting the development of new programs. The program holds 6 weekly 2-hour sessions that involve groups of 20-30 participants in discussions on various aspects of nutrition, exercise, and stress management. Workshop leaders present slides, films, and lectures and supply participants with a Health Plus workbook providing health information and exercise directions. The program particularly focuses on family

units and also targets young and middle-aged residents who have the potential for risk factor reduction through lifestyle change. Three separate instruments designed to measure health knowledge, practice, and attitude are administered to workshop participants prior to the first session and after the sixth session, and biographical data is collected to determine general characteristics of participants. Evaluation of more than 200 participants revealed increased feelings of control and responsibility for personal health status and an increased ability to set and follow through with a health behavior goal.

SCHOOL HEALTH EDUCATION

81-0782
Smoking Sam Goes to School.
Bode, P.; Cran, C. G.; and Christen, A. G.
Journal of School Health 50(9):510-513, November 1980.

"Smoking Sam" is a smoking education activity for students in grades 1-5 in San Antonio, Texas, that uses a mannequin that inhales cigarettes and accumulates tars and nicotine in artificial lungs. The presentations, offered to groups of 60-90 students, incorporate group discussion, lecture, demonstration, and student participation in the skit. Topics included are heart disease, lung cancer, emphysema, house and forest fires, bad breath, and the effects of smoking on athletics and various dental conditions. At the conclusion of each skit, students are asked to inspect Sam's lungs and smell his bad breath, and are then given the American Cancer Society pamphlet describing smoking hazards. 3 references.

81-0783
A Breast Self-Examination Program for High School Students.
Carstenson, R. and O'Grady, L. F.
American Journal of Public Health 70(12):1293-1294, December 1980.

A pilot program of breast self-examination (BSE), implemented in nine Sacramento, California, high schools, included an American Cancer Society film and trained volunteers to lead discussion and answer questions. A physician spoke on the medical aspects of breast cancer, and a nurse gave BSE instruction. Questionnaires were administered to all participants after the program, and 1 year later to senior classes in one school district. Approximately 90 percent of the respondents felt that BSE programs were acceptable for presentation to all high school females. Respondents also indicated an increased practice of BSE, with noncompliance resulting from forgetfulness rather than fear or embarrassment. 3 references.

81-0784
Health Education Objectives--Kindergarten through Grade 12.
Department of Defense, Washington, D.C. Dependents Schools.
Washington, D.C., the Pentagon, Department of Defense Dependents Schools (DS Manual 2700.3), 60 p., August 16, 1978.

An outline of school health education objectives is provided. The curriculum covers consumer health; environmental health; family dynamics; growth, development, and aging; mental health; physical fitness; preventive health; safety; human sexuality; and legal and illegal substances. Each area is divided into several subtopics, which contain student objectives relating to knowledge, intellectual processes, attitudes, and psychomotor skills (if applicable). Although topics remain the same for each of four levels (K-3, 4-6, 7-9, and 10-12), student objectives become more sophisticated at each succeeding level.

81-0785
Idea Exchange: Health Issues in Cook County Suburban Public Schools.
Educational Service Region of Cook County, Chicago, Ill. Public Information Office.
Chicago, Ill., Educational Service Region of Cook County, Public Information Office, 24 p., February 1978.

An overview of several health education programs developed and implemented by suburban public schools in Cook County, Illinois, is offered. Programs reviewed include courses; clinics; and comprehensive curricula in high-level wellness, pediatric orientation, screening and referral, medical care, family living, physiology and pathology, first aid, safety, physical therapy, nutrition, smoking cessation, hearing conservation, and venereal disease.

81-0786
Comparative Effectiveness of Smoking Prevention Programs.
Jason, L. A. and Mollica, M.
Paper presented at the Annual Convention of the American Psychological Association (87th, New York, N.Y. September 1-5, 1979), 23 p., September 1979.
Available from: ERIC, Order No. ED-179 062.

One hundred and forty-nine ninth graders were involved in an antismoking intervention program aimed at assessing the comparative effectiveness of role playing and discussion versus discussion alone. Sixty-six ninth graders enrolled in a different high school acted as a control group. Within each experimental class, current smokers were identified, placed in pairs, and randomly assigned to one of two intervention modes. Each of the classes in the experimental school was divided into groups of 9-10 students; two groups participated in discussions and two groups participated in discussion and role playing. The role playing portrayed immediate negative consequences perceived by the individual, immediate negative consequences perceived by others, and long-term health hazards. All students involved in any aspect of the program completed demographic forms and provided information concerning smoking habits and peer pressure to smoke. While both treatment modes effectively reduced levels of smoking, few changes were noted for youngsters with entrenched habits. These data suggest that early prevention programs might be most effective in curtailing smoking among schoolchildren. 32 references.

81-0787
Integrating the Teaching of Sickle Cell Anemia Into the Curriculum of the Cincinnati Public School System.
Jones, R. L.; Smith, C. H.; and Cox, E.
Journal of the National Medical Association 72(2);105-109, February 1980.

To determine the impact of the Cincinnati (Ohio) Comprehensive Sickle Cell Center's educational program, the level of sickle cell knowledge among elementary and high school students in the Cincinnati public school system was measured. Research was based on a pre- and posttest control group design that involved 22 teachers and 1,880 elementary and high school students, and consisted of curriculum development, experimental design development, inservice training for experimental group teachers, project implementation, and evaluation. Findings supported the hypothesis that use of the sickle cell teaching curriculum in conjunction with inservice training provided by the sickle cell education staff was more effective than the use of teaching materials alone or use of the regular science curriculum. In addition, findings suggested that more experienced teachers were better at incorporating special curricula into their regular classroom programs, and that imparting sickle cell knowledge to the general and at-risk populations through inservice training, seminars, and workshops is an effective and practical use of sickle cell educational staff. Implications of the findings are examined. 6 references.

81-0788
Daily, Dry Toothbrushing in Kindergarten.
Lee, A. J.
Journal of School Health 50(9):506-509, November 1980.

The effectiveness of dry toothbrushing in regard to oral health was investigated in 10 kindergarten classes. A questionnaire was distributed to teachers at the end of the project to determine who had conducted the toothbrushing, for what period of time, what advantages and disadvantages for children and teachers were found, and reasons for suspending toothbrushing if teachers did so. Results revealed that only 3 of 10 teachers who initiated the toothbrushing continued throughout the 6-month program. In the seven cases in which toothbrushing was stopped, toothbrush storage was cited as a factor in one situation, and length of time in the other six instances. Messiness was another disadvantage cited. Positive program effects included an increased awareness of dental health by the children and more meaningful discussions about health by the teacher. Based on questionnaire data, six classrooms with similar socioeconomic and ethnic backgrounds were selected for a second screening. Three classrooms served as control groups. Results revealed significantly improved oral cleanliness among students who participated in the daily toothbrushing, and demonstrated the program's overall effectiveness. 16 references.

81-0789
Health Education of Young People in the USSR.
Loransky, D. N. and Karataeva, N. B.
International Journal of Health Education (Geneva) 23(3):162-166, 1980.

The Central Institute for Scientific Research in Health Education, Ministry of Health of the Union of Soviet Socialist Republics, has accumulated information on the content and methods of health education among children and adolescents. This information has contributed to the development of long-term curriculum planning based on the principles of continuity, singleness of purpose, and differentiation. Greatest efficiency results from the application of a specific system which draws on the complementary influences of the health and educational sciences. Implementation is possible only if the school and home environment are conducive to positive health habits and if there is gradual transition from one age group to another. Specific health education programs are designed after an analysis of school health programs, students' physical health status and morbidity rates, medical and pedagogical research findings, and student curricula. All necessary information related to knowledge and habits is

divided into eight main areas: protective value of physical exercise and strengthening of individual health, mental health, health aspects of polytechnical training, social and personal health, infectious disease prevention, nutrition education, accident prevention, and sex education. 9 references.

81-0790
A Nutrient Approach in the Fifth Grade.
Meyers, L. D. and Jansen, G. R.
Journal of Nutrition Education 9(3):127-130, July-September 1977.

A nutrition education unit utilizing a nutrient approach was tested in fifth grade classes. To visualize the process by which nutrients contribute to a meal's nutritional content, nutrients, measured as a percentage of recommended dietary allowances, were summed on an abacus. During the first part of the unit, students studied cellular needs for specific nutrients. Cartoon characters, color-coded to match the abacus, provided an introduction to the 10 nutrients studied. During the second part, students examined cellular needs for a variety of nutrients and the food sources providing such nutrients. Unit effectiveness was evaluated by a nutrition knowledge pre- and posttest and by teacher and student comments. Results revealed a significant improvement in test scores for all groups exposed to the nutrition unit; control groups demonstrated no such improvement. Participating teachers were enthusiastic about the materials developed and the interest evoked in students. Strengths and weaknesses of the nutrient abacus approach are discussed. 13 references.

81-0791
Food and Nutrition Supplementary Resources: A Selective Annotated Bibliography for Elementary Schools, K-6.
Minnesota State Dept. of Education, St. Paul. Child Nutrition Section.
St. Paul, Minn., the Department, 17 p., 1977.
Available from: ERIC; Order No. ED-142 305.

An annotated bibliography of books in print that provide supplementary resources on food, nutrition, and related topics is provided for use by elementary school teachers. All books listed were judged factually accurate and suitable for elementary school students; each citation indicates suggested grade level. Titles are arranged according to these categories: folktales and fiction, nutrition and food, exercise and weight control, plant food, meat, food technology, food experiments and activities, food and the outdoors, gardens, food producers and agribusiness, cultural and customary food preparation techniques, world food dynamics and hunger, consumerism and food, and careers in food.

81-0792
Tobacco Education Curriculum: Junior High. Health Education: Substance Abuse Prevention.
New York State Education Dept., Albany. Bureau of Drug Education.
Albany, N.Y., the Department, 87 p., 1979.
Available from: ERIC; Order No. ED-180 986.

Instructional units and a sampling of teaching methods, concepts, and objectives for a tobacco education curriculum are presented. The tobacco education section is part of a comprehensive curriculum that was assessed by 152 elementary and secondary school teachers in 17 urban and rural school districts in New York State. All concepts and objectives are considered basic, although choices are provided in the selection of actual activities. Each unit, designed to reinforce a major concept about smoking, lists suggested learning activities as well as instructional materials to be used and resources available to the teacher. Major concepts addressed include social and psychological determinants of smoking, effects of smoking on health, difficulties in breaking the smoking habit, and advertising methods used by the tobacco industry to persuade young adults to smoke. Fact- and worksheets are included, and a list of the addresses and telephone numbers of county offices of the American Cancer Society is appended.

81-0793
Planning Health Education Programs in Oregon Schools: Physical Health.
Oregon State Dept. of Education, Salem. Basic Education Section.
Salem, Ore., the Department, 64 p., 1979.
Available from: ERIC, Order No. ED-175 872.

Learning activities for health education are outlined for Oregon elementary and high school students. The theme of the curriculum is the relationship of physical health to other health factors. A statement summarizing the course or unit goal precedes each suggested activity and is followed by related activities in other study areas. The learning activities are separated for primary, intermediate, junior high, and senior high students. Within each grade level, major categories of activities include the relationship of physical health to other factors, influence of social factors on physical health, influence of nutrition on physical health, patterns of human growth and development, body systems, current health practices, abusive behavior, and physical health resources.

81-0794
Planning Health Education Programs in Oregon Schools: Community Health.
Oregon State Dept. of Education, Salem. Basic Education Section.
Salem, Ore., the Department, 71 p., 1979.
Available from: ERIC; Order No. ED-177 130.

A curriculum designed to aid the development of community health education programs in Oregon schools is presented for use by elementary and secondary school teachers and curriculum planners. The curriculum includes seven suggested course or elementary-unit goals accompanied by suggested learning activities. While giving purpose and direction to curriculum planning and analysis, the curriculum allows local districts to map their own course. Topics addressed at the primary, intermediate, junior high, and senior high grade levels, are the relationship of community health to other health factors, factors that influence community health, influence of environmental conditions on community health, disease control and prevention, community health problems, health careers, and community health resources.

81-0795
Curriculum Guides for Nutrition Education.
Smith, M. K. and Phillips, J.
Journal of School Health 50(7):371-376, September 1980.

The Mississippi State Department of Education, in conjunction with the University of Mississippi School of Education, has developed nutrition education curriculum guides for grades K-3 and 7-12 and for food service managers and employees. The guides include a basic concept followed by unit goals, evaluation, specific objectives, learning experiences to accomplish specific objectives, suggested resource materials, and designated teaching areas. Learning experiences are provided for use in mathematics, art, English, science, journalism, home economics, social studies, typing, health, consumer affairs, contemporary affairs, reading, and career education classes. Teachers may select, adapt, and implement any activity suitable to their students' abilities and age level. Teaching aids for the grades 7-12 curriculum include games, books, pamphlets, films, and nutritional factsheets. After developing the curriculum, two teaching teams were selected and trained to use the nutrition materials. These teachers have conducted workshops for teachers on curriculum deployment in 20 designated areas throughout the State. Outlines of each guide are provided.

81-0796
Primary Prevention of Cancer Beginning in Childhood.
Williams, C. L.
Preventive Medicine 9(2):275-280, March 1980.

Recent findings in cancer research suggest that most human cancers can be prevented if appropriate lifestyle habits are begun in childhood and maintained throughout life. The Know Your Body (KYB) program has demonstrated that cigarette smoking onset can be prevented in children 12-14 years old and that behavior change in regard to improved nutritional habits can be achieved in children using peer group interaction and behavior modification activities. In addition, personalizing the curriculum with medical screening or a health passport, through which children receive their own screening results, can be effective in reducing major chronic disease risk. Three major tasks confront child health educators: (1) to continue to improve the effectiveness of risk reduction interventions; (2) to ensure that effective health education programs are available to the greatest number of children; and (3) to develop a commitment from government, community, and school leaders to verbally and financially support meaningful school-based health education. 11 references.

81P-0797
Basic Aid Training (BAT).
American National Red Cross, Youth Services, 17th and D Streets, N.W., Washington, DC 20006
1978 - Continuing.

The Red Cross Basic Aid Training (BAT) course is designed to introduce fourth graders to practical safety and first aid techniques. Seven lessons cover (1) emergency assistance; (2) fires; (3) home emergencies (poisons, choking, eye injuries, and falls); (4) home emergencies (wounds, nosebleeds, and electricity-related injuries); (5) emergencies away from home; (6) mouth-to-mouth resuscitation; and (7) cleanliness and safety. All elements of each lesson are outlined in an instructor's guide, which is available as part of the BAT kit. The kit also contains a series of posters to emphasize topics presented to the students. The program is available to anyone teaching fourth grade students. BAT instructor-trainer candidates must complete a self-instruction course before applying for certification. Persons under 17 years of age can become instructor's aides.

81P-0798
Biofeedback Smoking Education Project.
King, P.
New Hampshire Lung Association, P.O. Box 1014, 456 Beech Street, Manchester, NH 03105
1977 - Continuing.

The Biofeedback Smoking Education Project of the New Hampshire Lung Association's Secondary School Health Education Program was developed to help student smokers quit and to help nonsmokers reinforce their decision not to smoke. High schools participating in the program are provided with a tested educational program, biofeedback equipment on loan, and professional orientation services. Groups of five to six students experience the educational and biofeedback components of the program together, and parental involvement is encouraged. The program is available for use by all high school students in the State. The efficacy of each school's program is assessed via pre- and postprogram questionnaires, the latter administered 6 months after the end of the program. Control schools are used for comparison. An assessment completed by the State lung association following the 1979-80 school year revealed that (1) 21 percent of the smokers surveyed said they would decrease their cigarette consumption; (2) 16.6 percent of the cigarette smokers had stopped smoking; (3) 87 percent of the nonsmokers stated that their decision not to become cigarette smokers was reinforced; and (4) 90 percent of all participants stated that they would recommend the program to their friends.

81P-0799
Project CHarlie.
Strawbridge, C.
5701 Normandale Road, Edina, MN 55424
Funding Source: Edina Public Schools, Minn.
1977 - Continuing.

Project CHarlie (Chemical Abuse Resolution Lies in Education) works with children in grades K-6 to help them explore their values, strengthen their ability to make responsible decisions, learn about themselves, and prevent drug abuse. Project CHarlie is a classroom program that combines the efforts of prevention specialists and regular teachers to address the causes of drug abuse, namely, low self-esteem, peer pressure, and lack of healthy peer relationships. Classroom methods include group discussion, written activities, audiovisual presentations, and role playing. Four curriculum units cover self-awareness, relationships, decision making, and chemical use in society. Teacher training services offered by the project include monthly 1-hour information sessions, 1-day information sessions for school faculty who want to implement the curriculum, 2-day workshops for specialists, and 5-day workshops offered twice each year for community planners who want to introduce the curriculum into their communities. In December 1977, the program was introduced into the six elementary schools in Edina, Minnesota. By the end of the 1978-79 school year, 2,000 Edina children had participated. Program efficacy is being monitored by surveying former participants as they pass into adolescence. In one such assessment, 175 seventh grade participants performed significantly better than the 150 matched controls on knowledge of peer pressure and feelings of self-esteem.

SELF-CARE

81-0800
Patient Compliance With a Home Parenteral Nutrition Program.
Hughes, B. A.; Fleming, C. R.; Berkner, S.; and Gaffron, R.
JPEN. Journal of Parenteral and Enteral Nutrition 4(1):12-14, January-February 1980.

A systematic study of patient compliance with home parenteral nutrition (HPN) (a means of managing patients with severe nutritional problems who otherwise would spend much of their time in the hospital) was conducted by an independent nurse who visited 10 patients and families at varying periods after HPN implementation. A compliance scale was based on aseptic technique assessment, sequence of steps followed, safety precautions, proper equipment usage, and knowledge of complications. Compliance percentiles ranged from 73 to 97, with a median of 95. Seven patients scored 90 percent or more in overall compliance. Patient knowledge of potential HPN complications was the only category in which patients were deficient. Factors that correlated positively with a high compliance score were male sex, absence of children in the home, and wives who were enthusiastic about HPN and who offered strong moral support. Findings suggest that patients with chronic disabling diseases of the small bowel and severe malnutrition can be managed safely at home with HPN if they are properly trained and supervised. 6 references.

81-0801
Project Health PACT In Action.
Igoe, J. B.
American Journal of Nursing 80(11):2016-2021, November 1980.

Project Health PACT (Participatory and Assertive Consumer Training) prepares children to be responsible health

consumers. They are encouraged to ask questions, communicate information about themselves to the health professional, encourage the health professional to provide them with health instruction, participate with the health professional in making decisions, and clarify the responsibilities they are to assume for their own health maintenance. Nurses and physicians, who participate in 2-day training seminars, teach group and individual lessons. A special course has been formulated to prepare children for the new consumer role and to teach them a number of self-help activities. An experimental study involving students in eight fifth-grade classes in Colorado proved that the program made significant positive differences in terms of health knowledge, internalization of health locus of control, and attitude toward professionals. Incorporation into the program of active problem solving by the children has been effective. 4 references.

81-0802
Healthwise Handbook.
Roberts, T. M.; Tinker, K. M.; and Kemper, D. W.
Garden City, N.Y., Doubleday (Dolphin Books), 250 p., 1979.

Guidelines to help the layperson make decisions about common health problems are offered to supplement the advice of medical professionals. Topics include home physical examinations, abdominal problems, backaches, headaches, respiratory problems, skin ailments, injuries, emergencies, dental care, nutrition, mental wellness, home health centers, medicine chests, family medical records, and healthy lifestyles.

81-0803
The Decision to Regain Control.
Sachse, M.
Diabetes Educator 6(3):22-23, Fall 1980.

Diabetics who have rejected the "restriction-free" approach may find help in home blood-glucose-monitoring strategies. The procedures have been especially helpful in working with patients in the Self-Monitoring and Management of Diabetes study at the University of Colorado Health Sciences Center. Personal experiences with home monitoring practice are related.

81-0804
A Preliminary Inquiry Into Physicians' Perceptions of Patient Self-Control.
Shapiro, J. and Shapiro, D. H., Jr.
Journal of Medical Education 55(8):704-708, August 1980.

The need for physicians to train patients in self-control skills was investigated in a small pilot study that surveyed 16 obstetrician-gynecologists regarding their patients' degrees of self-control relative to medical problems. Findings revealed a confusion among respondents about the concept of self-control and its applicability to patient care. Areas of patient care in which the use of self-control skills could be beneficial include diet and eating habits, hygiene, exercise, drug abuse, smoking, alcohol consumption, family planning, selection of a sexual partner, venereal disease, and family relationships. Five respondents felt that their patients exhibited too much control in the areas of sex, work, and emotional expression. Three respondents indicated that their patients exhibited an appropriate amount of self-control in the areas of hygiene, labor and delivery, and compliance with medical advice. Respondents were most interested in learning about self-control strategies such as behavioral self-management, biofeedback, meditation, and self-hypnosis and autogenic training. Suggestions for further research are provided. 19 references.

81P-0805
Dystrophic Epidermolysis Bullosa Research Association of America (DEBRA).
Pessar, A.
2936 Avenue W, Brooklyn, NY 11229
January 1980 - Continuing.

The Dystrophic Epidermolysis Bullosa Research Association of America (DEBRA) is a private, nonprofit organization of parents offering mutual support and outreach to other families with children who suffer from this skin disorder. DEBRA publishes a quarterly newsletter; retains a medical advisory board to represent association interests to the professional community; and retains a national board of trustees to promote the interests of affected families among professional, business, and laypersons throughout the country. DEBRA hopes to reach the estimated 5,000 victims of dystrophic epidermolysis bullosa and their families as well as any professionals who may be able to help them.

SEX EDUCATION

81-0806
A Sex Education Program That Worked.
Carrera, M. A.; Baker, E. A.; and McCombs, K. F.
SIECUS Report 6(4):6, March 1978.

Following intensive training, 24 staff members of a boys' residential treatment center in New York City initiated a pilot sex education program for 80 boys 8-14 years old. The staff divided into eight teams of three and provided a 1.5-hour-per-week class. Weekly and final measurement and evaluation was determined by using the Socio-Sexual Knowledge and Behavior Test. Statistically significant gains in knowledge, attitude shifts, and the ability to use new knowledge were noted. The program was conducted without disruption to the primary programs at the center.

81-0807
Gaining Community Acceptance of a Sex Education Program.
Cox, D. H.
Ft. Lauderdale, Fla., Nova University, 72 p., June 15, 1979.
Available from: ERIC; Order No. ED-180 974.

A study committee comprising students, teachers, and parents from the New Trier Township High Schools in Northfield and Winnetka, Illinois, was convened to study, plan, and implement a sex education program. The committee was convened in response to a petition signed by 1,500 students, parents, and teachers, asking for assistance in helping young people deal responsibly with their sexuality. The committee studied the educational methods of other schools in the Chicago area, wrote a statement of philosophy and purpose for sex education, reviewed a model sex education program, and served as an important communication point with the community. A curriculum for a 3-week information course was written and implemented in the community's two high schools. The evaluation suggested that the objective of gaining community acceptance of the program was met. Furthermore, the local board of education commended the program and approved it for a second year. The appendices contain assessment questionnaires, the curriculum, a report prepared by the teachers of the program, and copies of letters sent to the committee. 8 references.

81-0808
The Theory and Practice of Behaviour Change in the School Context.
Emery, M.
International Journal of Health Education (Geneva) 23(2):116-125, 1980.

Teaching strategies to encourage responsible sexual behavior among members of a class of 14- to 15-year-old low-ability pupils are outlined, and means to help teachers use these strategies are discussed. Class topics, which are examined via discussion or role playing, include (1) the options of no premarital sex, premarital sex using contraception, and premarital sex without using contraception; and (2) considerations and consequences of abortion. Teaching considerations include (1) the need to clarify teaching objectives and investigate pupils' values and beliefs, particularly relative to consequences; (2) the role of pressures and constraints in the formation of health behaviors; (3) avoidance of negative pressures; (4) the use of fear and distractors to influence health decision making; and (5) the need for teachers to think in behavioral terms and not only in terms of imparting knowledge. 7 references.

81-0809
Family Life Education: Teacher Selection, Education, and Training Issues--A Selected Bibliography.
Figley, C. R.
Family Coordinator 26(2):160-165, April 1977.

A keyed bibliography lists family life education publications concerned with teacher selection, education, and training. Each publication's emphasis--certification standards, family life education, historical sources, course and program development, sex education, and teacher selection and training--is indicated

81-0810
Community-Based Feminist Programming for Girls: An Approach to Pregnancy Prevention.
Frankford, E. R.
Paper presented at the Annual Meeting of the National Council on Family Relations (Philadelphia, Pennsylvania, October 19-22, 1978). 16 p., October 21, 1978.
Available from: ERIC; Order No. ED-179 061.

The Discovery and Awareness for Women Now (DAWN) program was organized to prevent adolescent pregnancy and childbearing through a community-based feminist social service effort aimed at teenage girls in the Lower East Side of Philadelphia. Developed by a coalition of six agencies, the program was designed to increase awareness and skills, develop positive self-images, and engage women in activities that promote their physical and mental well-being. The program staff conducted training workshops for staff, sponsored events in which women planned the next 10 years of their lives, developed role-playing sessions, sponsored presentations by leading women in the area, planned and implemented cultural evenings and programs to help other groups, held workshops in obtaining part-time employment, sponsored sports events and

trips, provided sex education activities, and generally approached pregnancy prevention in a holistic manner. Evaluation data on sexual activity, pregnancy, sexual knowledge, knowledge of birth control methods, and women's vocational aspirations indicated that, due to the program, the girls had more sexual knowledge, claimed to participate in sexual activities less frequently, and used contraceptives more often.

81-0811
Student Evaluations of a Required Sex Education Course.
Gammon, E. and Zisook, S.
Journal of Medical Education 55(4);372-374, April 1980.

One hundred and fifty-six medical students evaluated a required 14-hour sex education course presented over 4 months at the University of Texas Medical School at Houston. A form designed to evaluate the first 9 hours of the course asked students to rate style of presentation on a four-point scale, judging content and interest as well as perceived usefulness in medical practice. Findings revealed that (1) 93 percent of the respondents indicated that sex education should be required for all students; (2) 98 percent affirmed that the course had the highest quality of instruction in the behavioral science curriculum; (3) group discussions followed by films and lectures were rated as most useful; (4) the most highly rated sessions were those offering a patient education approach to sexual themes in medicine; (5) many students thought the course paid too much attention to sexuality; and (6) 22 percent called the course "boring." Implications of these findings are discussed. 9 references.

81-0812
A Pediatrician's View.
Levine, M. I.
Pediatric Annals 9(3):84-87, March 1980.

Experiences with pregnant teenagers from upper and lower class families in the United States, a brief examination of sex education and efforts to deal with adolescent pregnancy in Denmark, and an overview of a symposium on pediatric pregnancy offer insight into the problems of sexual experimentation among teenagers. About 1 million women under 20 years of age become pregnant in the United States each year. Of these, 560,000 bear children, 330,000 have induced abortions, and 110,000 have spontaneous abortions. Teenagers in low socioeconomic classes are more likely to carry the fetus to term than teenagers in high socioeconomic classes due to the lack of stigmatization concerning pregnancy and the presence of informal community support systems. Concentrated sex education programs, which include demonstrations with contraceptives, and strict paternal responsibility laws have proven successful in controlling teenage pregnancy in Denmark. The symposium topics cover the medical and psychosocial risks of adolescent pregnancy and childbearing, nutrition and the pregnant adolescent, a study of the 60,000 infants born to adolescent mothers, contraception during adolescence, and the potential for child abuse among adolescent parents.

81-0813
Sexuality Education in a State Mental Hospital.
Shaul, S. and Morrey, L.
Hospital and Community Psychiatry 31(3):175-179, March 1980.

A sex education program was initiated for patients in an adult transitional living program at Western State Hospital, a State-owned psychiatric facility in Steilacoom, Washington. Nurses, an obstetrician-gynecologist, a psychologist, the county family planning director, a health educator, and a sex education consultant designed the curriculum, gearing it toward staff training and patient education. Two series of training sessions were held for the hospital staff to discuss sexual issues and provide information on birth control and sexually transmitted diseases. Patient education sessions lasted 1-1.5 hours and were led by a family planning educator. During a 16-week period, the program incorporated (1) responses to written questions about sex or family planning; (2) short lectures on family planning or sexual response; (3) values clarification strategies followed by group discussion; (4) films; and (5) printed materials on birth control, sexually transmitted diseases, and parenting. Although no formal evaluation was conducted, the team observed that participants were attentive during most of each session, rarely left before sessions were completed, and behaved in a highly appropriate and socialized manner. Recommendations for sex educators involved in similar programs are given. 7 references.

81-0814
Integration of Physiological and Sociocultural Factors as a Basis for Sex Education to the Elderly.
Shomaker, D. M.
Journal of Gerontological Nursing 6(6):311-318, June 1980.

A framework for sex education of the elderly is presented that considers (1) the development of sexual norms and moral codes which stipulate that sex is primarily for procreation and should cease when reproductive capability

terminates; (2) sociocultural aspects of elderly sexual behavior, including guilt feelings among those who wish to continue sexual activity, the loss of an established role in society, and diminishing opportunities for meaningful relationships because women outlive men; and (3) physiological and biological changes which affect sexuality. Nurses can provide sex education in a small group format in a manner that (1) dispels myths through factual presentations; (2) presents tasteful and accurate outlines of anatomical and physiological changes as they relate to sexual response; (3) explores feelings of guilt resulting from sexual stereotyping; (4) allows persons to discuss their feelings and thoughts; and (5) validates and reevaluates norms and values according to individual needs. Recommendations for forum instructors are given that emphasize the need for good communication skills. 24 references.

81-0815
Answering Questions About Sex.
Yarber, W. L.
Science Teacher 44(3):20-22, March 1977.

Sex education teachers should (1) discuss issues dealing with sexuality and interpersonal relationships, (2) encourage a relaxed classroom atmosphere, (3) understand students' questions, (4) consider both male and female viewpoints, (5) help students understand different ethical attitudes about sex, (6) assure students that past sexual behavior does not determine future behavior, (7) encourage students to use scientific terminology, (8) allow adequate time for discussion, and (9) provide a question box for anonymous inquiries. Educators should not (1) dominate the discussion, (2) relinquish their adult role, (3) interrogate students about their sexual behavior, (4) impose their value system, (5) feel the necessity of offering an opinion, (6) discuss their sexual behavior, (7) allow student nervousness or uneasiness to end discussion, (8) or attempt to determine the types of questions that will be asked. 5 references.

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Teen Reach.
O'Hare, D.
Medical and Health Research Association of New York City, Inc., Maternity, Infant Care--Family Planning Projects (MIC-FP), 377 Broadway, New York, NY 10013
Funding Source: Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
April 1978 - December 1980.

The Teen Reach program is a health service project designed to provide maternity and family planning services to low-income adolescent women in New York City. The program assigns family planning consultants to each participating school to discuss pregnancy and related topics with students in formal classroom settings, conduct informal discussions with individuals or small groups of students, acquaint students with sources of health care and health-related services, refer problems beyond the limits of their responsibility to school administrative personnel, and conduct clinic tours for students. A Teen Reach office is established in each school so that teenagers know where to go for information or help; the office is staffed by paraprofessionals who have at least 10 years' experience as counselors. During the 1979-80 school year, girls attending high school in the Bronx, Brooklyn, Manhattan, and Queens formed the target population. Program activities are evaluated by the student participants, school personnel, and the family planning consultants.

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CURRENT AWARENESS IN HEALTH EDUCATION

SEPTEMBER 1982, Part 1

81-0817—81-0990

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INTRODUCTION

Current Awareness in Health Education (CAHE) is published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents acquired and selected by the Center. CAHE also contains descriptions of programs in health education. These descriptions are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources. To make the information in CAHE timely, only documents published or programs of relevance since 1977 are included.

Copies of each document and supporting documentation for each program description are stored in the Center's permanent collection. Users of CAHE are urged to consult local public, medical, and university libraries for individual copies. Sufficient information is provided in the citations to enable users to locate copies or to contact programs.

All persons receiving CAHE are invited to contribute copies of pertinent documents and descriptions of relevant programs for possible inclusion. The Center also welcomes any comments on CAHE and suggestions to improve its usefulness. Write or call:

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Education
Attn: Current Awareness in Health
Education
Building 14
Atlanta, GA 30333
(404) 329-3235
FTS 236-3235

Tearsheets for submitting program documents and descriptions of relevant programs are provided on pages vii-viii.

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HOW TO USE CAHE

CAHE contains two types of records: informative abstracts of published literature and descriptions of ongoing programs. These records are arranged in chapters according to their major subject area. Chapter headings are used to group items generally related and include: Community Health Education; Health Education in Occupational Settings. Health Education Methodology; Patient Education; Professional Education and Training; Regulation, Legislation, and Administration; Research and Evaluation; Risk Reduction; School Health Education; Self-Care; and Sex Education. The chapter headings reflect active areas in health education as well as major interests of the Center for Health Promotion and Education. To locate specific items of interest, users are encouraged to use the extensive Subject, Author, and Program Title indexes found in the back of each issue.

Within each chapter, citations and abstracts of documents appear first, followed by descriptions of programs. Abstracts with their citations are arranged in alphabetical order by the primary author's name, and descriptions of programs are arranged in alphabetical order by the title of the program.

Each document and program description has a unique accession number. Accession numbers of documents consist of a two-digit prefix indicating the year of acquisition by CAHE and a four-digit number indicating the publication sequence of the document. For example, 79-0022 indicates the 22nd document acquired by CAHE in 1979. Program accession numbers have a similar format with a "P" added following the year to indicate program, e.g., 79P-0025 indicates the 25th item acquired by CAHE in 1979, and that the item is a program.

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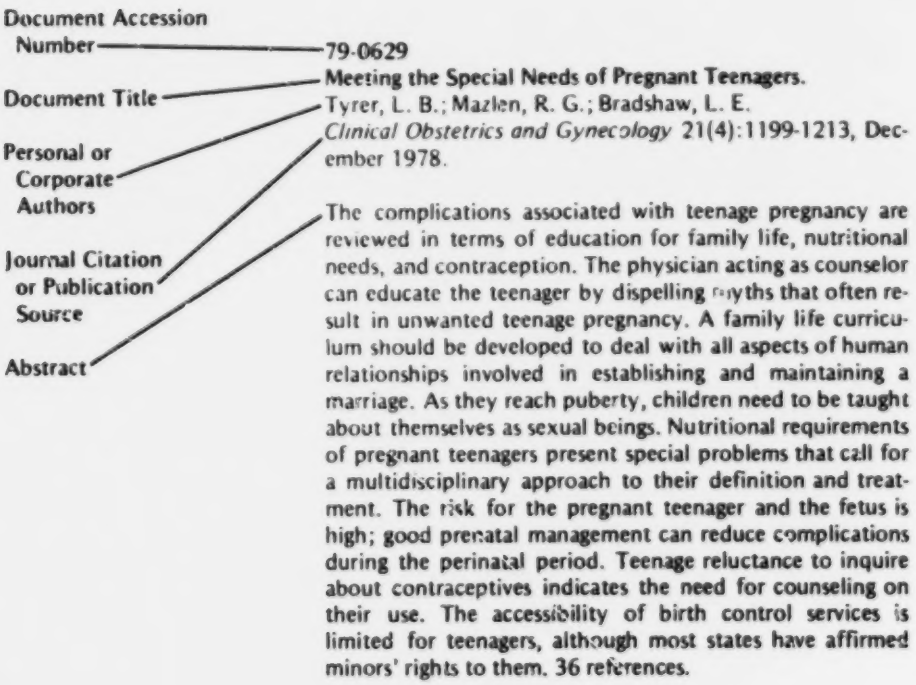
Document Accession Number
79-0629
Document Title
Meeting the Special Needs of Pregnant Teenagers.
Personal or Corporate Authors
Tyrer, L. B.; Mazlen, R. G.; Bradshaw, L. E.
Journal Citation or Publication Source
Clinical Obstetrics and Gynecology 21(4):1199-1213, December 1978.
Abstract
The complications associated with teenage pregnancy are reviewed in terms of education for family life, nutritional needs, and contraception. The physician acting as counselor can educate the teenager by dispelling myths that often result in unwanted teenage pregnancy. A family life curriculum should be developed to deal with all aspects of human relationships involved in establishing and maintaining a marriage. As they reach puberty, children need to be taught about themselves as sexual beings. Nutritional requirements of pregnant teenagers present special problems that call for a multidisciplinary approach to their definition and treatment. The risk for the pregnant teenager and the fetus is high; good prenatal management can reduce complications during the perinatal period. Teenage reluctance to inquire about contraceptives indicates the need for counseling on their use. The accessibility of birth control services is limited for teenagers, although most states have affirmed minors' rights to them. 36 references.

The distributor from which a document cited in CAHE is available to the public may be given as the last element in the citation. The most commonly cited distributors and their acronyms are listed below. Price information may be obtained from the supplier at the address given by specifying the order or stock number of the document and the form, hard copy or microfiche, desired. If the document is available from a distributor other than those listed, such as directly from the author, the address of that alternate distributor is provided.

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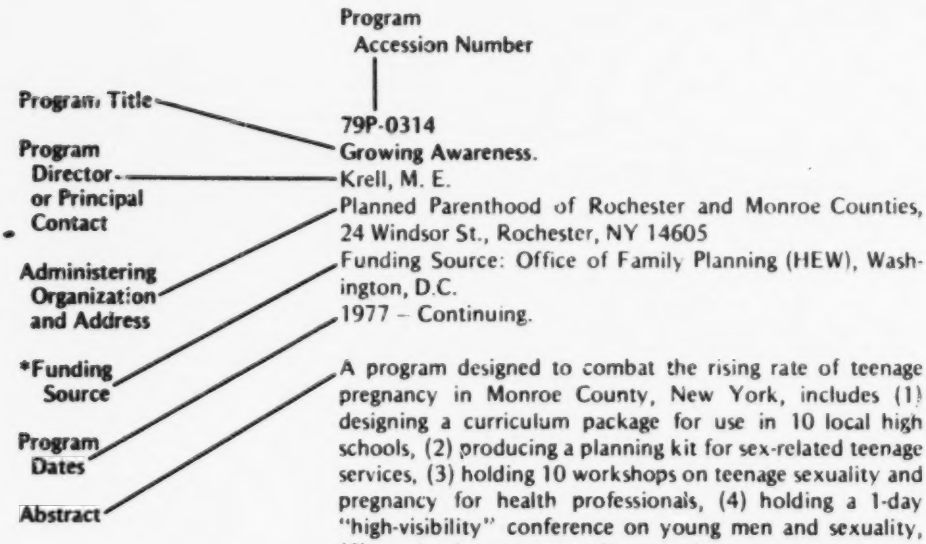
Program Accession Number
Program Title
Program Director or Principal Contact
Administering Organization and Address
*Funding Source
Program Dates
Abstract
79P-0314
Growing Awareness.
Krell, M. E.
Planned Parenthood of Rochester and Monroe Counties, 24 Windsor St., Rochester, NY 14605
Funding Source: Office of Family Planning (HEW), Washington, D.C.
1977 – Continuing.
A program designed to combat the rising rate of teenage pregnancy in Monroe County, New York, includes (1) designing a curriculum package for use in 10 local high schools, (2) producing a planning kit for sex-related teenage services, (3) holding 10 workshops on teenage sexuality and pregnancy for health professionals, (4) holding a 1-day "high-visibility" conference on young men and sexuality, (5) conducting a mass media campaign to attract teenagers, and (6) establishing a hotline. An Adult Advisory Group and a Teenage Advisory and Reaction Group participate in the program.

CAHE contains three indexes. They are: (1) Author, which contains the names of personal and corporate authors of documents and directors of programs; (2) Subject, which contains subject descriptors, including geographic location, for both documents and programs; and (3) Program Title, which contains names of programs that are either mentioned in documents or detailed in program descriptions.

*The funding source is specified if the program receives funds from institutions other than the administering organization.

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PROGRAM DATA SHEET

The Center for Health Promotion and Education is collecting information about current health education programs for use in *Current Awareness in Health Education* and in analyzing program trends in the field. A program may provide identification, public awareness, coordination, training, demonstration, etc.

If you wish to share your program efforts with other health education professionals, please complete the form below, being as specific as possible in providing information.

We greatly appreciate your taking the time to share your experience with us.

---

1. Program Identification:

   Official Title of Program or Grant and Grant No: _____

   Official Name of the Organization Conducting the Program: _____

   _____

   Address of the Organization:

   _____
   street city state zip code

   Program Director: _____
   name title telephone area code number

   Principal Contact (if different from Program Director): _____
   name title telephone area code number

   Beginning Date of Program: _____ Ending Date, If known: _____

2. Funding Source for Your Program:

   Please provide the Name(s) and Location(s) (City, State) of Funding Source(s):

   _____

   _____

   _____

3. Focus of Program: _____ Administration _____ Community Health Education _____ Health Education Methodology

   _____ Nutrition Education _____ Occupational Health Education _____ Patient Education

   _____ Professional Training Programs _____ Research and Evaluation _____ Risk Reduction _____ Sex Education

   _____ School Health Education Other _____

4. Target Population(s): _____

5. Purpose of Program. Please describe the primary purpose of your program

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Publications/Information Materials: Please send copies of any publications or material describing your program, if available, or give complete citation (author, title, date, publisher). If no publications exist or are planned, please state how further information may be obtained.

   _____

   _____

   _____

   _____

   _____

THANK YOU.

(Please cut along dotted line)

Name, Title of Person Submitting Program Information

Organization

Street

City, State, Zip Code

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Atlanta, GA 30333

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COMMUNITY HEALTH EDUCATION

81-0817
National Clearinghouse for Alcohol Information.
Alcohol Health and Research World 5(1):35-36, Fall 1980.

Established in 1972 as a prevention service of the National Institute on Alcohol Abuse and Alcoholism, the National Clearinghouse for Alcohol Information collects and disseminates information on all aspects of alcohol abuse and alcoholism. Among the information products and services provided by the clearinghouse are directories of alcoholism treatment programs in all 50 States; fact sheets on topics of interest in the field; summaries of Federal and State legislation; and booklets, posters, and flyers for public awareness campaigns. The clearinghouse also features a data base containing over 38,000 documents relating to program efforts and scientific and technical advances. The clearinghouse receives over 125,000 requests each year from health professionals, teachers, students, labor leaders, business executives, scientists, alcoholics and their families, and others. About 10,000 persons contacting the center due to personal problems related to alcoholism were referred to treatment programs or other community resources last year. Community outreach services provided by the clearinghouse include exhibits at national association conferences, orientation conferences at the clearinghouse, demonstrations at conferences, mail campaigns aimed at association memberships, and indepth program assistance to selected groups.

81-0818
The Community Health Information Network: A Model for Hospital and Public Library Cooperation.
Gartenfeld, E.
Library Journal 103(17):1911-1914, October 1, 1978.

The Community Health Information Network (CHIN), a cooperative library network established between a Cambridge, Massachusetts, community hospital and six public library systems, is discussed in light of the patient-consumer health education movement and its health information demands on hospital libraries. CHIN was implemented in 1977 and is currently funded by four grants. Services include (1) an interlibrary loan system to allow public libraries access to health-science library resources; (2) reference information; (3) compilation of bibliographies; (4) information on referral to community health service agencies; (5) identification and acquisition of a core collection of health science materials for the public library; and (6) a series of health education programs presented in public libraries. To ensure that network libraries are involved in project planning, a group of librarians from all participating institutions meets monthly. Means to ensure the liability of librarians who provide medical information to health care consumers, and other ethical, moral, and legal issues associated with the operation of CHIN are examined. 8 references.

81-0819
A Course in Self-Care for Rural Residents.
Irish, E. M. and Taylor, J. M.
Nursing Outlook 28(7):421-423, July 1980.

Two health education programs, planned and implemented by rural recipients and their health professionals, serve the Chebaque and Peak Islands of offshore Maine. The first program resulted from the residents need to (1) know more about self-care and illness prevention, (2) perform basic clinical procedures, (3) use health care resources more effectively, and (4) save money when obtaining health care services. Classes were limited to 25 participants and covered home medicines, high blood pressure and arteriosclerosis, health insurance, body awareness, physician consultation, dental care, nutrition, common injuries, and assumption of responsibility for personal health. A similar program involved 17 participants in classes on preventive health maintenance, common illnesses, health and nutrition, home medicines, general psychiatry, clinical skills, common injuries, medical emergencies, cardiopulmonary resuscitation, alcoholism, and breast self-examination. Both programs were coordinated by a nurse who selected experts to conduct specific sessions. Evaluations, based mainly on anecdotal data, indicate that participants were better able to care for themselves and their families than they had been before taking the classes, had developed greater personal responsibility for good health, and had acquired practical skills and the confidence to use them.

81-0820
The Juvenile Intervention Program: Results of the Process, Impact and Outcome Evaluations.
Iverson, D. C. and Roberts, T. E.
Journal of Drug Education 10(4):289-300, 1980.

The Juvenile Intervention Project (JIP) is an education and intervention program in Toledo, Ohio, for 12-17 year old drug abusers. JIP involves six weekly 2-hour working sessions in which drug knowledge, communication styles, self-esteem, manipulation in the family setting, and expression of emotion in the family setting are discussed. The program also includes individual and family counseling. Evaluation data have been analyzed for random samples of 64 juvenile participants who completed the program between January 1977 and April 1978 and between May 1978 and August 1978. In addition to a pre- and postprogram test, participants were asked to complete a one-page questionnaire to assess their participation at the completion of each session. Followup data were collected 6 months after completion of each program cycle. Analysis of the data indicated that the program positively affected family communication patterns, self-esteem levels, and drug knowledge levels through the followup period. Followup data also indicated that school drug problems and criminal justice system contacts declined significantly and that there was a significant reduction in drug use. 3 references.

81-0821
Health Education in the Hospital.
Nwana, O. C.
Nigerian Nurse (Lagos) 9(2):19-20, 23, April-June 1977.

There are very practical considerations, beyond the patient's right to know, for supporting patient education. Hospitals are ideal facilities for health education because they represent a centralization of medical expertise and because they employ nonmedical staff who can not only benefit from health education themselves, but also help health professionals reach out to the community. A health education program should (1) confine its scope to the resources available, or make the appropriate arrangements to acquire necesary resources; (2) provide health education and encourage behaviors that support health; (3) encourage personal interaction between the clinician and the patient in all situations from bedside to consulting room; (4) use group education sessions in which patients share a common need or condition; and (5) teach healthy lifestyles by example.

81-0822
Clergy Health Day: Ministering to the Ministers.
Opferman, J.
Hospital Progress 60(1):38, January 1979.

Mercy Hospital in Port Huron, Missouri, sponsored a Clergy Health Day. Blood testing, urinalysis, and chest X-rays were performed and the test results were sent to each clergyman's physician. After the examination, presentations were provided on nutrition, preventive health care, mental health, and spiritual health. The participants were unanimous in expressing their appreciation of the event.

81-0823
Pierce County Health Education Development Guide.
Pierce County Health Council, Tacoma, Wash. Health Education Committee.
Seattle, Wash., Puget Sound Health Systems Agency, Public Information Office, 45 p., September 1978.

The guidelines for the development of a comprehensive community health education and promotion campaign in Pierce County, Washington, are presented. Topics include steps in developing the plan, a model of the health education system, basic health education and promotion resources available to the community, and functions and criteria of an organized system. A survey of community health agencies and health care providers and a summary of findings of a county school health study implemented in 1976 are appended. 6 references.

81-0824
Because You Care: Let's Talk About Cancer.
Pohl, C. R.
Supervisor Nurse 9(4):54-55, April 1978.

As part of the rehabilitative effort of the oncology unit at Baptist Medical Center in Oklahoma City, a human-caring course is offered to help family members, medical center employees, and others understand the lifestyle needs of cancer patients. Participants meet for 1 hour twice a week for 4 weeks. The sessions involve instruction in the cancer personality, the relationship of traumatic loss and cancer, stress and the body's immune system, and the emotional needs of the person living with cancer. Group discussions and exercises serve to enhance the familiarity of the participants with ways to address emotional needs of the patients. Participants are encouraged and taught to listen to others in a manner that encourages emotional expression. Patients are encouraged to share their thoughts, experiences, and feelings with at least one family member, rather than with a hospital employee. More than 150 people have attended the course or some portion of it, and the response has been encouraging. Physicians have begun to actively refer patients to the program.

81-0825
Health Education in Bophuthatswana.
Robertson, B. and Lekgetha, A. N.
Curationis (Pretoria) 1(4):4-7, March 1979.

Formal health education efforts in Bophuthatswana began in 1975 with the establishment of the Department of Health and Social Welfare. The community education and immunization services division of the Department controlled educational activities concerned with family planning, dietetics, environmental hygiene, and mental hygiene, and organized a mobile health unit to assist general health programs, health needs, and health exhibitions. A 1977 survey of nine regional hospitals indicated that (1) poor nutrition, tuberculosis, typhoid fever, diarrhea, and babies born without the aid of midwives were the most important problems; (2) little evaluation of educational programs had been implemented; (3) hospitals had access to more sophisticated materials than clinics; (4) no training was given to health education workers; and (5) more emphasis was needed on health education, particularly at the regional level. The plan developed to respond to these findings included establishing a national health education unit to develop an overall policy, initiating special community education projects, organizing refresher courses and inservice training for health workers, establishing an audiovisual center, establishing a liaison with the mass media, evaluating educational field services, and executing relevant health education research.

81-0826
Educating the Consumer About Emergency Medical Services.
Young, M.; Ponder, L. D.; and Hurlev, R. S.
Health and Social Work 3(3):173-181, August 1978.

A council of county governments representing a seven-county rural region in central Texas received over $500,000 under the Emergency Medical Services (EMS) Systems Act of 1973 to improve the quality of EMS available to residents. A program of public education and information was subcontracted to the Department of Health and Physical Education at Texas Agricultural and Mineral University. The educational component utilized a sociological model for community involvement through identification and use of persons known as initiators, legitimizers, diffusers, and followers. Community awareness was developed through a series of seminars, during which community leaders and the lay public were brought together to learn and disseminate information about the components of a quality EMS system. Representatives who attended the regional seminar served as leaders of the followup seminars in their home counties. The local seminars were publicized by means of mail campaigns, open letters published in local newspapers, and releases to newspapers and radio stations. The county seminars included slide presentations, lectures, group discussions, and a discussion with a panel of EMS experts. The educational program led to followup activities by local service clubs, the League of Women Voters, and local television stations.

81P-0827
"Hotline to the Health Team" Radio Program.
Ellerton, M. L.
Dalhousie University, School of Nursing, Halifax, Nova Scotia, B3H 3J5, Canada
September 1979 - Continuing.

The "Hotline to the Health Team" Radio Program is designed to increase public awareness of community services in the Halifax-Dartmouth area and to publicize the Dalhousie University School of Nursing. Each monthly 2-hour show is cohosted by a faculty member of the nursing school and a radio announcer. Use of a different faculty member each month gives each broadcast a different focus. The show consists of a 20-minute discussion of some aspect of physical and emotional health, followed by calls from listeners. Most of the phone responses come from women who are coping with stressful situations such as parenthood, menopause, or retirement; each show receives an average of 12-15 calls and approximately six letters.

81P-0828
Cardiovascular Health Promotion Project.
Foster, M. K.
Ontario Heart Foundation 576 Church Street, Toronto, Ontario, Canada M4Y 2S1
June 1979 - December 1981.

The Cardiovascular Health Promotion Project of Barrie, Ontario, is a community-based and -targeted strategy for enhancing healthy cardiovascular lifestyles through the development of a model employing volunteers and other community resources. The project designed a self-management skills package that focuses on diet, physical activity, stress, and smoking. In addition, the project identifies and trains volunteers to educate program participants, advertises the availability of the heart health program, enlists community participation, and evaluates the impact of the program. Strategies used to develop community awareness include presentations to groups of health professionals; contact with volunteers at four community service groups; operation of an information booth at a local shopping center; coordination of a mail cam-

paign, newspaper articles, and public service announcements; and distribution of promotional flyers. The project's target audience includes the population of Barrie, with special emphasis on the approximately 2,400 employees of the city's 12 industries. Seventy-six people, 25-73 years old, participated in the course. Before and after the course, participants filled out attitude and behavior questionnaires, had their blood cholesterol tested, and participated in the University of Toronto fitness assessment.

81P-0829
Center for Health Enhancement Education and Research.
Kleeman, C. R. and Fielding, J. E.
University of California, Center for the Health Sciences, Los Angeles, CA 90024
1978 - Continuing.

The Center for Health Enhancement, Education, and Research was established to (1) develop and teach effective methods of preventing and reducing the effects of degenerative disease, (2) promote good health and well-being through positive changes in health habits, and (3) provide a research, education, and service program combining the multidisciplinary resources of the University of California at Los Angeles Department of Kinesiology and the Schools of Medicine, Public Health, and Nursing. Health enhancement service programs include a 24-day live-in program designed for persons with heart disease; a concentrated half-day program to provide comprehensive medical care, supervised practice, and education; and several health promotion programs for employees at specific worksites. Employee worksite programs provide an overall health profile of a company, screening and health risk appraisals for cardiovascular disease and cancer, and risk reduction programs. The Center sponsors radio and television campaigns and public lectures, promotes development of school health education programs, provides inservice training for professionals and health education training to medical students, and sponsors continuing education symposia and classes. Seven research and evaluation studies are underway. The 40-member multidisciplinary staff includes experts in medicine, nursing, public health, exercise physiology, nutrition, and psychology.

81P-0830
The Great American Smokeout.
American Cancer Society, 777 Third Avenue, New York, NY 10017
1977 - Continuing.

The Great American Smokeout, held each year on the Thursday before Thanksgiving, is designed to convince at least one in every five smokers to abstain from smoking on the day of the program. The program appoints an honorary celebrity chairperson each year to promote the campaign. Program staff meet with top management of American companies for organizational purposes, provide promotional material, persuade workplace celebrities to quit smoking on smokeout day, enlist exsmokers to staff company hotlines on Smokeout Day, promote use of local community and company news organs to advertise the campaign, create crisis centers in companies, promote intercompany competitions, send members of the American Cancer Society (ACS) to act as cessation clinic facilitators, arrange other ACS programs on smoking cessation, and otherwise promote company and community efforts to encourage smoking cessation. A Gallup survey of the 1979 effort indicated that nearly 15 million Americans attempted to refrain from smoking on Smokeout Day; approximately 5 million succeeded for a full 24 hours; 2.3 million continued to abstain for 1-3 days; and 7.8 million reduced the number of cigarettes they smoked.

81P-0831
Hypo Psycho Band.
West, N.
Winter Haven Hospital, Inc., Winter Haven, FL 33880
September 1977 - Continuing.

The Hypo Psycho Band provides health education through a bluegrass music show. The band performs for service clubs, schools, churches, and audiences at mobile home parks, offering health education presentations between songs. Topics have included smoking, alcohol abuse, nutrition, exercise, healthy lifestyles, new patient services offered at the hospital, and hospital cost containment. From September 1977 through November 1980 the band performed 126 times. Although the band has several alternate members, a performance is generally given by six hospital employees, including five musicians and a nurse, all of whom volunteer their time. No formal evaluation has been made of the band's teaching effectiveness.

81P-0832
Maine Alcohol, Other Drugs and Highway Safety Prevention-Intervention Project.
Isaly, J. K.
Station No. 23, Augusta, ME 04333
Funding Source: National Highway Traffic Safety Administration, Washington, D.C.
December 1, 1978 - Continuing.

The Maine Alcohol, Other Drugs, and Highway Safety Prevention-Intervention Project attempts to decrease the rate of accidents associated with alcohol and drug abuse in the State. The central element of the strategy is the development of core school and community teams, in which youngsters and adults are educationally prepared to implement programs in their own schools and communities. Programs are spread through a series of instructional levels with trainees (core teams) at one level becoming trainers at the next level. The teams develop plans that already have resulted in a variety of programs, including policy alteration efforts aimed at school administrators and school board members, community-based parental educational programs, a peer counseling program, a media awareness campaign during the 1979 Christmas holiday season, and interventions that result in referral of alcohol- and drug-dependent youth for appropriate medical treatment. Core teams include school superintendents, principals, guidance personnel, school board members, teachers, students, parents, law enforcement officers, members of the clergy, selectmen, and alcohol and drug treatment staff. See also 81P-0960.

81P-0833
McDowell Community Outreach Development Program.
Goldenberg, D. M., et al.
Ephraim McDowell Community Cancer Network, Inc., 915 S. Limestone St., Lexington, KY 40503
Funding Source: National Cancer Inst. (DHHS, NIH), Bethesda, Md.
August 1977 - July 1981.

The McDowell Community Outreach Development Program organizes local medical, lay, and agency representatives to provide guidance and resources to identify and implement cancer control projects for specific regions in Kentucky. Services of the six regional program offices (three in western and three in eastern Kentucky) include a hotline providing information on prevention and environmental health, dissemination of an environmental health brochure series, implementation of screening and detection programs through local health departments, provision of inservice education for nurses, implementation of a public information campaign utilizing the cooperative extension model, development of cancer programs in community hospitals, operation of a tumor registry, education for health professionals, and provision of continuing care for the terminally ill through a regional outpatient hospice program.

81P-0834
Michigan Health Council Health Promotion Project.
Auer, H. A.
Michigan Health Council, Suite 340, Nisbet Building, 1407 S. Harrison Road, East Lansing, MI 48823
Funding Source: W. K. Kellogg Foundation, Battle Creek, Mich.
1980 - Continuing.

The Michigan Health Council (MHC) Health Promotion Project was founded to (1) help other organizations initiate and expand health promotion activities, (2) establish statewide networks of individuals and organizations involved in health education and promotion, (3) develop new health promotion programs, (4) help the Michigan School Health Association codify and coordinate health programs throughout State schools, and (5) promote health activities for elderly and rural residents. MHC is a private, nonprofit, voluntary health education organization which has been in operation since 1943. The project will develop an inventory of health promotion activities and materials and will encourage their use by other organizations. MHC task forces will teach health habits through community organizations and agencies and will offer leadership workshops. Specific attention in the project will be given to the needs of the elderly, rural residents, and schoolchildren. Upon completion of a study by Central Michigan University students, a telephone directory of school health resources within the State was published and is currently being distributed.

81P-0835
Montgomery County, Arkansas, Health Education Advisory Committee.
Henderson, B. U.
Arkansas Cooperative Extension Service, Courthouse, Mt. Ida, AR 71957
1973 - Continuing.

The Montgomery County, Arkansas, Health Education Advisory Committee is a volunteer citizen action group that identifies health needs in the county and develops plans of action to meet those needs. Health promotion activities sponsored by the program have included behavior modification classes; immunization campaigns; cardiopulmonary resuscitation training; physical fitness classes; nutrition education; dental health education; and health maintenance clinics in which county residents are screened for high blood pressure, glaucoma, diabetes, and other conditions. Since its organization in 1973, the committee has sponsored 12 different educational and health promotional activities. The program serves an isolated rural county of 7,500 persons with minimal health

services. The 25-member committee is representative of the county and is cooperatively sponsored by the Cooperative Extension Service and the Arkansas Department of Health.

81P-0836
Multipurpose Arthritis Center.
Bennett, J. C., et al.
University of Alabama in Birmingham, School of Medicine, Dept. of Medicine, 1919 7th Ave. S., Birmingham, AL 35233
Funding Source: National Inst. of Arthritis, Metabolism, and Digestive Diseases (DHHS, NIH), Bethesda, Md.
September 1977 - August 1981.

The Multipurpose Arthritis Center (MPAC) at the University of Alabama in Birmingham coordinates existing arthritis programs and initiates new demonstration programs designed to increase knowledge concerning the pathogenesis of rheumatic diseases, improve health education and patient services related to the diseases, and encourage a more enlightened community attitude toward the diseases. Research at the MPAC includes senior faculty working in immunology, molecular biology, connective tissue biochemistry, and clinical rheumatology. Educational activities include professional, allied health, and postgraduate activities within the university as well as public and patient education within the community. Activities of the community program component bring MPAC into contact with all of the public and private agencies and groups involved with arthritis and rheumatic diseases at local, State, and regional levels. In addition to feasibility proposals in fundamental research, MPAC sponsors demonstration projects and studies in patient utilization of unproven remedies, undergraduate nursing education, patient referral patterns, public education via the health extension system (HELP), education in industry for arthritis prevention, inpatient education in arthritis, and a nationally based curriculum study by the Delphi method. The program is a multidisciplinary effort by faculty and staff of the medical school, dental school, nursing school, school of community and allied health, and the university hospitals and clinics.

81P-0837
Project Choice--Cancer Prevention Is Your Choice.
Hutchinson, W. B., et al.
Fred Hutchinson Cancer Research Center, 1124 Columbia St., Seattle, WA 98104
Funding Source: National Cancer Inst. (DHHS, NIH), Bethesda, Md.
September 1979 - March 1981.

Project Choice is a model program designed to teach schoolchildren, school personnel, parents, and related community organization members in Washington about cancer prevention and to develop a comprehensive statewide plan for cancer education. Services include developing prototypes of cancer education materials for elementary and secondary schools and community organizations, developing training programs for school and community instructors, testing and evaluating materials and training programs in a pilot project area, and developing plans for statewide implementation if funding becomes available. An evaluation plan is being developed to test all materials and to test the efficacy of the overall program objectives.

81P-0838
Sudden Infant Death Syndrome Counseling and Information Program.
Williams, D. A.
Bureau of Community Health Services, Office for Maternal and Child Health, Room 7-36, 5600 Fishers Lane, Rockville, MD 20857
1974 - Continuing.

The Sudden Infant Death Syndrome (SIDS) Counseling and Information Program provides for examination and certification of victims of SIDS as well as counseling and education for parents. Services include collecting and analyzing SIDS cases; providing educational programs for health care providers, public safety officials, and the public; distributing articles, pamphlets, and films; providing voluntary counseling services to families, and establishing advisory councils for SIDS projects. In the area of information collection and analysis, the program provides for autopsies for all infant victims of sudden and unexpected deaths, certification of SIDS on death certificates, and transfer of research findings into health care delivery services. Material distributed by the program includes a directory of SIDS information and counseling project grants. The primary target audience is the families of the 7,500 yearly victims of SIDS in the United States. Involved professionals and public health officials are also targeted. Volunteer counselors include program physicians, nurses, social workers, psychologists, physicians, religious leaders, and members of voluntary organizations.

81P-0839
Think Health.
Deere, R.
University of Arkansas, Division of Agriculture, Cooperative Extension Service, 1201 McAlmont, P.O. Box 391, Little Rock, AR 72203
1977 - Continuing.

"Think Health" is a seven-session workshop focusing on stress management, cardiovascular health, and lifestyle change. Prior to implementation of the workshops, health education staff participated in inservice training seminars conducted by faculty members of the University of Arkansas for Medical Sciences and the Graduate School of Social Work. Medical faculty conducted sessions on heart disease, exercise, smoking, diet and weight control, and stress; social work faculty conducted workshops on counseling and group dynamics. From August 1977 through June 1978, five health specialists from the Cooperative Extension Service conducted the seven weekly workshops in 12 counties in Arkansas. A total of 782 participants enrolled; 80 percent of participants were women. The specialists conducted assessments, interpreted health hazard appraisal questionnaires, answered questions, conducted workshop sessions on various topics, and encouraged participants to reach their goals of raising their level of wellness. A 12-month followup of 10 percent of the participants indicated that 69.3 percent of those enrolled completed the program and that those who completed the program made positive changes in knowledge, attitudes, and health practices.

81P-0840
We Care for You.
Ramirez, A. G.
Baylor College of Medicine, Office of Public Affairs, Texas Medical Center, Houston, TX 77030
1978 - Continuing.

The "We Care for You" health promotion program promotes family immunizations, medical emergency preparedness in the home, and communication with children in the family. The program produces 30- and 60-second public television spots that promote free brochures that can be ordered by telephone. Each brochure describes a single health topic, recommends specific behavioral changes, and describes available community resources. All respondents receive followup telephone calls to determine their address, how they heard of the program, and the reason for requesting the information. Editorials and several print and television news stories have aided in the promotion of the program, which reaches over 25 percent of Houston's 800,000 households and generates over 25,000 requests for the brochures. Pre- and postcampaign telephone surveys are conducted in association with each campaign. Survey results indicate that the campaign produced some positive changes in health behavior.

81P-0841
X Rays: Get the Picture on Protection.
Hayes, A.
Food and Drug Administration, Bureau of Radiological Health, 5600 Fishers Lane, Rockville, MD 20857
March 1980 - Continuing.

The "X Rays: Get the Picture on Protection" program educates consumers about the benefits and risks of X rays. The program disseminates a folder that contains (1) a brochure that describes X ray benefits and risks and explains ways that consumers can help in radiation protection, (2) a bookmark listing consumer actions in X ray protection, (3) an X ray record card, (4) a poster and a brochure on X rays and pregnancy, (5) a table-top easel on X rays and pregnancy, (6) a brochure explaining dental X rays, (7) a reprinted radiation primer, (8) a reprint on reducing genetic risk, (9) a brochure on X ray scans, (10) an X ray picture book, (11) a reprint on the benefits and risks of X rays, (12) a form for X ray and vaccination records, and (13) an annotated bibliography of patient and consumer materials on medical radiation. The folder is distributed upon request by the Consumer Affairs Office of the Food and Drug Administration in Minneapolis, Minnesota.

81P-0842
Youth Gives a Damn (YGAD).
Loya, R. V.
Huntington Park High School, 6020 Miles Avenue, Huntington Park, CA 90255
1969 - Continuing.

"Youth Gives a Damn" (YGAD) is a statewide coalition of California high school students who use after-school hours to work on projects that promote good health for themselves, their families, and their communities. YGAD's major project consists of a series of health camps convened in various locations. Several hundred participants attend a variety of health education sessions, lasting from 16 to 72 hours, that include lectures, films, and panel discussions on death and dying, sexuality, venereal disease, drug abuse, cancer, and cigarette smoking. Other projects coordinated by YGAD members have included participation in the "Great American Smokeout" sponsored by the American Cancer Society (ACS), distribution of leaflets on the availability of emergency community immunization clinics, participation in the March of Dimes "Superwalk '80," provision of staff for health screening clinics for the elderly, and participation in numerous other community aid programs. The primary target group consists of adolescents 9-12 years old. Currently, there are 25 local affiliate organizations and chapters throughout the

State. An experimental group of 140 youths were administered pre- and postprogram test in association with a YGAD health camp. Followup questionnaires will be mailed at 1- and 2-year intervals. A control group of 40 high school students not involved in the YGAD program will be tracked in the same manner as the experimental group. Preliminary results indicate an increase in knowledge and volunteer rates as a result of participation in the program. YGAD receives funds from local offices of the ACS, the American Lung Association, the American Heart Association, the Red Cross, county medical associations, the March of Dimes, and civic groups such as Rotary, Kiwanis, and parent teacher associations.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-0843

Du Pont's Occupational Health and Safety Program.

American Industrial Hygiene Association Journal 41(6):A46, A48, A50, A52, June 1980.

The occupational health and safety program at Du Pont includes a program of formal medical surveillance, implemented in 1915; a Safety and Fire Protection Division, created in 1926; the Haskell Laboratory for Toxicology and Industrial Medicine, founded in 1935; a formal epidemiology program, developed in 1956; and a computerized personal environment record system, initiated in 1979. A communication network allows rapid transmission of pertinent information to affected workers. The experience of Du Pont in the field of occupational health and safety indicates that (1) the greatest progress is made when government stipulates what must be done and leaves the methods of reaching these goals to industry; (2) special handling of substances with only slight carcinogenic properties may prove extremely costly and provide only minor protection benefits; (3) some chemicals that pose other than carcinogenic or embryotoxic risks are not controlled by government regulations; (4) a reasonable connection should be established between a regulation's cost and its benefits before adoption; and (5) many proposed regulations concerning risk assessments go far beyond legislative mandates and realistic needs.

81-0844

Hypertension Control Programs in Occupational Settings.

Alderman, M. H.; Green, L. W.; and Flynn, B. S.
New York, N.Y., Cornell University Medical College, 15 p., 1979.
Available from: NTIS; Order No. HRP-0030861.

The occupational setting may provide the optimal environment for hypertension control programs. It is estimated that cardiovascular disease and stroke accounted for $50 billion in direct and indirect health costs in 1976; this represents 20 percent of all health-related expenditures. Hypertension is a major cause of cardiovascular disease and stroke, and, of all cardiovascular risk factors, is the most responsive to available interventions. Detection, referral, and followup of hypertension in the occupational setting are embodied in such programs as the Chicago Heart Association Project, the Michigan Worker Health Program, and the Burlington Industries Program. Studies involving the occupationally-based treatment of hypertension indicate that a rigid therapeutic approach, reliance on a health team, removal of personal financial impediments, emphasis on patient participation in the treatment process, and provision of services within a socially cohesive facility are more important determinants of patient outcomes than the physical location of a treatment facility. Insurance companies, such as the Blue Cross Association (with support from the National Heart, Lung, and Blood Institute), have become interested in the development of programs to encourage blood pressure control activities in industry. Benefits resulting from educational strategies pertain to increased health care provider time, increased number of health care provider contacts, active patient participation, social support, and self-monitoring of blood pressure. 16 references.

81-0845

Health Behavior Change at the Worksite: A Problem-Oriented Analysis.

Chadwick, J. H.
Menlo Park, Calif., Health Systems Program, SRI International, 25 p., 1978.
Available from: NTIS; Order No. HRP-0030870.

The work setting provides a favorable environment for health promotion and outreach services. A systems approach to health behavior change that encompasses concepts, realities, problems, and opportunities will make the best use of the worksite for health education. Principal elements of health behavior change systems at the worksite are policy and ethics, welfare functions, funding sources, interorganizational agreements, self-care, worksite care, conventional care, patient education, information systems, physician education, planning and evaluation, and management. With regard to worksite care, some of the most important aspects include risk assessment, communication to participants, behavior as-

sessment, risk status monitoring, behavior status monitoring, risk reduction planning, and risk reduction interventions. Planning and evaluation needs pertinent to health behavior change involve health effects of interventions, behavioral effects, operations and costs of implementing programs, and benefits resulting from health effects.

81-0846

Self-Protective Measures Against Workplace Hazards.

Cohen, A.; Smith, M. J.; and Anger, W. K.

Cincinnati, Ohio, Behavioral and Motivational Factors Branch, Division of Biomedical and Behavioral Science, Natl. Institute for Occupational Safety and Health, 25 p., 1979.
Available from: NTIS; Order No. HRP-0030866.

Techniques to influence individual worker behaviors, actions, and attitudes in ways that facilitate greater self-protection against workplace hazards are examined. Training and reinforcement are directive means for targeting and strengthening specific worker actions. Critical considerations in this regard are (1) the use of training and reinforcement approaches that emphasize the learning of safe or healthful behaviors, (2) conditions of practice that ensure the transfer of learned behaviors to real situations, (3) performance goals for actions and frequent feedback to mark progress, and (4) meaningful rewards with an adequate reinforcement schedule and delivery system. Nondirective approaches are intended to create attitudinal change, a state of heightened awareness, or other dispositions favorable to self-protective actions. The emphasis is on communications, incentive, and management style factors as they relate to appropriate change in the health and safety consciousness of the worker. Fulfilling information needs about safety and self-protection through company incentives aimed at generating interest in job safety and health can be a byproduct of management's commitment to job safety and health matters. Field studies and the technical literature on directive and nondirective techniques offers supporting evidence for these arguments. 31 references.

81-0847

Perspectives of Industry Regarding Health Promotion.

Collings, G. H., Jr.

New York, N.Y., New York Telephone Co., 11 p., 1979
Available from: NTIS; Order No. HRP-0030867.

Several factors suggest the work setting as a favorable site for investigating the efficacy of heath promotion programs. Because efforts to produce substantial improvements in health within existing frameworks of government and the private health care system have not always been successful, opportunities for health promotion in the workplace are being increasingly recognized. The factors that make the workplace attractive for health system purposes include the increasing number of people, particularly women, who are in the workforce; the stability of the workforce; the ease with which periodic acquisition of data can be accomplished; the willingness of workers to participate in health programs offered in the work setting; and the Occupational Safety and Health Act and related legislation at both Federal and State levels that are extending the scope of health effects considered to be occupational in origin. The pervasive view is that health promotion consists of wellness improvement and disease prevention. The tendency to explore the promotion of individual health components in isolation is not viable; rather, business and industry should take an integrated approach to health care management so that a cost-effective basis can be established. The concept of risk identification is particularly important to such an approach.

81-0848

Smoking Cessation Programs in Occupational Settings: "State of the Art" Report.

Danaher, B. G.

Los Angeles, Calif., Division of Behavioral Sciences and Health Education, School of Public Health, University of California, Los Angeles, 28 p., November 15, 1978.
Available from: NTIS; Order No. HRP-0030864.

Business and industry have taken a growing interest in providing antismoking programs for employees. Research on smoking cessation methods reveals a number of promising directions that involve aversive smoking approaches combined with self-control strategies. Physician counseling is emphasized in some smoking cessation programs, but more interest is focused on the use of consultants or commercial programs. Businesses interested in promoting smoking cessation should increase the integration of in-house smoking cessation programs utilizing a variety of antismoking strategies; expand emphasis on behavioral skills training in addition to incentive programs for smoking control; improve research methodologies, including complete followup assessment and use of chemical tests for validating self-reported abstinence; use empirically tested recruitment procedures to involve as many employees as possible in a cost-effective manner; and promote interchange among behavioral scientists, professionals in occupational health, union and employee groups, and management. 46 references.

81-0849
The Control of Alcohol and Drug Abuse in Industry.
DuPont, R. L.
Bethesda, Md., Institute for Behavior and Health, Inc., 43 p., November 15, 1978.
Available from: NTIS; Order No. HRP-0030871.

The workplace may be an excellent setting for dealing with problems resulting from the use of alcohol and other psychoactive drugs. Industrial substance abuse programs are increasing in number due to concern over the well-being of workers and the maintenance of productivity. Employed persons have lower rates of alcohol and drug problems than unemployed persons, but the extent of substance abuse problems in the work force is large. Occupational programs are based on constructive confrontation (involuntary) and self-help (voluntary) approaches. There is a wide range of programs using health insurance benefits, industry-based treatment programs, and, the most common program, referral from the work environment to community substance abuse treatment resources. Further development of occupational programs should focus on research, prevention, unique needs of special groups, and extension of services to employees' families. 61 references.

81-0850
Weight Control and Nutrition Education Programs in Occupational Settings.
Foreyt, J. P.; Scott, L. W.; and Gotto, A. M.
Houston, Texas, Baylor College of Medicine, 35 p., 1979.
Available from: NTIS; Order No. HRP-0030862

The occupational setting offers a unique opportunity for weight control and nutrition education programs. The basic premise underlying behavioral treatment programs is that dietary changes involve substantial changes in eating behavior. Some form of self monitoring is employed in these programs, with self-control techniques consisting of observation of dietary behavior and self-recording of behavior in a notebook. Self-monitoring is useful because it gives individuals and persons working with them a record of dietary habits, and because the act of writing down food intake appears to have a positive effect on the diet. After self-monitoring for a certain period, individuals should begin to recognize certain patterns in their diet. Stimulus control techniques are often helpful components of dietary treatment programs. To be effective, these techniques must be designed creatively so that the procedures conform to the work or home setting. Other weight control methods include slowing the act of eating and implementing contingency management techniques in which individuals are rewarded for changing their diets. Evaluation of a typical program should include indices of cost effectiveness, attrition, followup, and confounding variables. 47 references.

81-0851
The Physical Activity Component of Health Promotion Programs in Occupational Settings.
Haskell, W. L. and Blair, S. N.
Washington, D.C., Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine (DHEW, PHS), 29 p., November 1978.
Available from: NTIS; Order No. HRP-0030865.

The inclusion of exercise as an essential component of health promotion programs in occupational settings is a promising trend. Benefits from physical activity are primarily related to the performance of large muscle dynamic exercises; vigorous forms of exercise seem to cause the greatest improvement in both physical working capacity and health. For both safety and effectiveness, exercise programs must be individualized according to interests, needs, and capabilities. Although little behavioral research has been conducted to determine the factors that contribute to effective initiation and maintenance of exercise programs by sedentary adults, available data indicate that factors influencing participation include effective program leadership, program convenience, support of peers and family, education and promotion, program variety and individualization, goal setting, evaluation, and recognition. Funding support is needed to explore the impact of increased exercise on job performance in both government and private industrial settings. 31 references.

81-0852
Stress Management in Occupational Settings.
Schwartz, G. E.
New Haven, Conn., Department of Psychiatry, Yale University School of Medicine, 25 p., 1979.
Available from: NTIS; Order No. HRP-0030863.

Over the past 10 years, substantial progress has been made in documenting the role that psychosocial stress plays in the etiology and development of physical and mental disorders, and in using behavioral procedures in the management of physiological and psychological responses to stress. Most research linking stress to illness, however, is not based on data derived from the occupational setting. The challenge facing industry, labor, and science is to design stress management programs that are clinically sound and cost-effective. Major types of psychosocial stress facing workers include work overload or work stagnation; extreme ambiguity or rigidity in relation

to tasks; extreme role conflict or little role conflict; too much or too little responsibility; competition; constant change and variability or routinized strategy; ongoing contact with so-called "stress carriers"; and interactions among carrier development, career opportunities, and management styles. One stress management procedure is assertiveness training, in which the goal is to help people assert themselves more appropriately to reduce the likelihood that they will engage in health risk behaviors. In many instances, assertiveness training programs combine behavioral therapy, imagery, role playing, and other techniques to improve subjects' ability to communicate. These methods as well as relaxation, meditation, biofeedback, and guided imagery have proven cost-effective and clinically sound. 37 references.

81-0853
A Perspective of Health Intervention Programs in Industry.
Whorton, M. D. and Davis, M. E.
Berkeley, Calif., Labor Occupational Health Program, Institute of Industrial Relations, University of California, Berkeley, 15 p., December 15, 1978.
Available from: NTIS; Order No. HRP-0030868.

A perspective on health intervention programs and their relation to the industrial environment is presented. The four key issues that must be addressed in health intervention programs revolve around the status of employees as a captive group of participants, the possible existence of a subtle coercion that ensures full participation or cooperation, the plausibility of pursuing health prevention programs in industry, and the possibility that health prevention programs are successful only when there is group participation. Concern for worker health should be shared by both management and physicians, with the latter being neutral in labor and management matters. The literature on this topic reveals more negative feelings toward occupational physicians than toward occupational nurses, industrial hygienists, and safety engineers. It is essential that employees be encouraged to participate in health programs and that these programs do not replace broad occupational health or environmental control programs. The screening of symptomatic versus asymptomatic patients, screening for hypertension, and testing for coronary artery disease and colon and rectal cancer are typical areas of concern of health programs. 15 references.

81P-0854
Center for Health Help.
Brennan, A. J. J.
Metropolitan Life Insurance Company, 1 Madison Avenue, New York, NY 10010
1977 - Continuing.

The Center for Health Help was organized in 1977 to help employees of the Metropolitan Life Insurance Company become informed consumers of health services and to enable them to take a more active role in caring for themselves and their families. Since then, the center has broadened its purpose beyond information dissemination to include active educational interventions. Programs are available on cholesterol management, diabetes management, nutrition, smoking cessation, and breast cancer. A stress management program and a pregnancy and parenting program are in the design stage. Methods include group discussion, lecture, self-help group activities, pamphlets, films, slide-tape presentations, and wall charts. Programs are formulated in response to data taken from employee surveys distributed as part of the company newspaper. The center is directed by a doctor of health education, who is assisted by a health education consultant. An outside expert is hired to evaluate each program, and center staff conduct minievaluations throughout each program. Program moderators and selected professional health educators are asked to react to suggestions concerning programming, intervention strategies, pertinent materials, and any other relevant aspects of the center. Base-line data on employee health will be computerized and assessed by outside evaluators.

81P-0855
Employee Personal Services--Stress Management Programs.
Pelligrino, J. F.
Mead Packaging, P.O. Box 4417, Atlanta, GA 30302
1975 - Continuing.

The Stress Management Program provided by Employee Personal Services at the Mead Packaging Company helps company employees deal with stress and develop positive mental and physical health habits. The program has provided assessment, counseling, and referral services since it began in June 1975, and has offered stress management seminars since February 1978. Prior to implementation of the program, a professional health counselor conducted an investigation of therapeutic resources available in the Atlanta area, drafted a policy and procedures statement, publicized the program throughout the company, and trained supervisors and managers in methods of identifying declining job performance and strategies for motivating troubled employees to seek assistance through the program. Two 6-hour seminars cover productive use of stress, physical fitness, relaxation, and effective cognitive practices. The program also confronts problems associated with stress, such as drug abuse and alcoholism. To

date, almost 100 salaried employees have attended the stress management program, and spouses are also encouraged to attend. Program outcomes have included a 40 percent increase in participation by salaried employees in the counseling and referral program, reports by seminar participants of increased control over general health, renewed workforce interest in physical fitness, and additional opportunities for the counseling and referral program to address various quality of worklife issues. The counseling and referral program has saved the company between $32,000 and $60,000 annually in reduced absenteeism.

HEALTH EDUCATION METHODOLOGY

81-0856
NIAAA New Public Education Campaign Targets Women and Youth.
Alcohol Health and Research World 5(1):14, Fall 1980.

The National Institute on Alcohol Abuse and Alcoholism has begun a 2-year effort to develop a mass media public education program focused on women and youth. The program will combine media messages with community organization and interpersonal communication efforts to influence change in specific problem behaviors. The major targets will be fetal alcohol syndrome, alcohol problems among women, and drinking and driving among young people. A network of State alcoholism agencies and intermediary groups will be mobilized to distribute materials and to develop program activities. The mass media effort will be developed and conducted under a $1.2 million contract by URSA (Urban and Rural Systems Associates)-Pacificon of San Francisco, and will be independently evaluated by Kappa Systems of Arlington, Virginia, under a $548,000 contract.

81-0857
Content Analysis of Teenaged Interviews for Designing Drug Programs.
Bell, E. V.
Journal of Drug Education 10(2):173-179, 1980.

Data from taped interviews involving teenage and adult interviewers and teenage interviewees provide recommendations for drug education and information programs. The interviewed subjects resided in East, Central, and West Harlem, New York. The study involved content analysis of data from 298 tapes. The interviewed teenagers recommended that (1) educational and informative programs for youth be developed; (2) parents and school personnel be included in educational and informational programs; (3) information be presented in an imaginative fashion, yet without detracting from the validity of the information; (4) young persons assume leadership as well as staff positions in all programs; (5) programs that depend on parents or teachers be carefully designed to deal with the distrust adolescents feel toward authority figures; (6) programs be designed and operated as community programs; (7) programs explain the effects of drug use and abuse; (8) programs in the ghetto counteract the image of the "hip drug user" as a role model; (9) programs in the ghetto appeal to ethnic pride; (10) a variety of media be used to present information in an interesting, compelling manner to appropriate age groups; (11) programs include supplementary activities; and (12) new institutional models for youth problem solving be considered. 5 references.

81-0858
Alcohol, Public Education, and Mass Media: An Overview.
Blane, H. T. and Hewitt, L. E.
Alcohol Health and Research World 5(1):2-14, Fall 1980.

An overview of alcohol prevention through mass media public education provides information on program efforts, alcohol-specific campaign evaluations, and countercommercials. The National Institute on Alcohol Abuse and Alcoholism; the Bureau of Alcohol, Tobacco, and Firearms; and the National Highway Traffic Safety Administration have sponsored public awareness campaigns on the effects of alcohol abuse. Of the voluntary agencies, the National Safety Council has the longest history of involvement in alcohol-related public education; other private or voluntary organizations in the field include the Allstate Insurance Company, the Foundation for Traffic Safety of the American Automobile Association, the National Council on Alcoholism, Alcoholics Anonymous, the Distilled Spirits Council of the United States, U.S. Brewers Association, and the 10-industry Beverage Alcohol Information Council. However, though a considerable number of messages is available from a variety of sources, the degree of public exposure to such ads is low due to the variety of competing messages and the generality of the typical message. Hence, though knowledge and attitude levels seem to be affected, drinking behavior goes unchanged. Several highly sophisticated evaluation designs as well as audience research and message pretesting techniques are being implemented. Negative advertising, using commercial as opposed to public service techniques, may be the most effective approach for the future. Numerous references.

81-0859
Perspectives: An AH & RW Interview Feature.
Chilcote, S. D., Jr.; Hutchings, R.; and Room, R.
Alcohol Health and Research World 5(1):39-45, Fall 1980.

An interview with the Associate Director of the Department of Health and Human Services Office on Smoking and Health, the Scientific Director at the National Alcohol Research Center Social Research Group at the University of California School of Public Health at Berkeley, and the President of the Distilled Spirits Council of the United States provides insights into the role of mass media public education efforts in prevention programming and the role of external controls on alcohol advertising. The effects of the temperance movement and the alcoholism movements demonstrate the importance of mass media education efforts in terms of practical and immediate changes and in terms of the symbolic statements they made. The media efforts of the Distilled Spirits Council are largely aimed at normal adults who consume alcohol in moderate amounts; the goal is to reinforce those practices and attitudes that keep most people within the normal range of consumption. Alcohol prevention programmers should look to the success antismoking forces had in requiring the broadcast industry (under the Fairness Doctrine) to run countercommercials in the 1960's and 1970's to balance cigarette advertisements. The situation with alcohol is more complex, since cessation need not be the goal. In the last 20-30 years, the national attitude toward alcohol has moved from viewing it as a substance that requires special treatment to viewing it as a commonly used commodity. However, in the area of alcohol abuse by pregnant women, the industry is mounting a massive campaign to reach 250,000 physicians and their female patients.

81-0860
A Critique of Values: Clarification in Drug Education.
Chng, C. L.
Journal of Drug Education 10(2):119-125, 1980.

Values clarification is widely used today in drug education programs in the United States. The premise behind its use is that decisions pertaining to drug use or abstinence are a direct function of a confused value system. The purpose of values clarification is to help individuals both structure and operationalize a value system that is personally satisfying and socially acceptable. One of the sharpest criticisms of values clarification concerns its excessive preoccupation with the process of valuing, which creates an illusion that it is devoid of content and, consequently, free of any moral communications. Thus, the role of information and knowledge in decision making is relegated to insignificance. The position of ethical relativism taken by users of values clarification strategies neglects the fact that the decisions to use drugs or to refrain from using drugs have moral implications. Conversely, it appears that those subjects whose values are incongruent with the "desired" values of the drug educator or program often become targets for "values teaching." The result is a form of indoctrination. A final, but obvious, shortcoming of the approach is its proclivity toward conformity to peer norms to the detriment of the personal development and clarification of values. 24 references.

81-0861
Nutrition Education for the Well Elderly--An Annotated List of Resource Materials and Canadian Programs.
Dumouchel, D.
Vancouver, British Columbia, Health and Welfare Canada, Health Promotion Directorate, 102 p., March 1980.

A selected listing is offered of printed and audiovisual educational materials (primarily Canadian) appropriate for use by the elderly person or the nutrition educator. The materials were collected by means of library searches, a DIALOG computer search, and a mail survey of 115 Canadian organizations that generated a response rate of 71.3 percent. In addition to audiovisual and printed material, materials describing techniques of developing programs, teaching aids and selected reference materials, and information on several nutrition education programs are also listed.

81-0862
Diets for Children and Adolescents That Meet the Dietary Goals.
Dwyer, J.
American Journal of Diseases of Children 134(11):1073-1080, November 1980.

Pediatricians should be competent to advise parents of elementary schoolchildren on means of implementing diets that meet the dietary guidelines of the Federal government. The Ten-State Nutrition Survey and the Health and Nutrition Examination Survey revealed that (1) minority group children suffered from lack of iron and vitamin A; (2) 30 percent or more of children from all income groups had nutrient intakes below the levels specified in recommended dietary allowances for iron, vitamin A, and ascorbic acid; and (3) intakes for both children and adolescents are higher in saturated fat, total fat, sugar, protein, and sodium than recommended levels. To correct this situation, and to ensure that children over 5 years old get all the nutrients they need, menus for schoolchildren should

substitute nutritionally balanced foods for foods such as fats and sugar; increase distribution of fruits and vegetables, breads and cereals, dried beans or peas, and starchy vegetables; and substitute alternatives for milk products, fatty meats, and eggs. 46 references.

81-0863
Teaching Eating and Toileting Skills to the Multi-Handicapped in the School Setting.
Gallender, D.
Springfield, Ill., Charles C. Thomas, 355 p., 1980.

Guidelines are provided for teachers to enable them to help multihandicapped students acquire self-help skills in eating and toileting. Topics include a historical overview of the handicapped, parental expectations, the role of the school, the neuromuscular system, mechanics of eating, early feeding and eating patterns, sucking skills, jaw movement and stability, lip closure and control, breathing patterns, drinking patterns, rotary chewing, reflexes, gag reflex, bite reflex actions, the tongue, dynamics of swallowing, processes of toileting, and evaluation of efforts to teach eating and toileting skills. A glossary is appended. 270 references.

81-0864
Drug Education Group Process: Considerations for the Classroom.
Garfield, E. M. and Jones, D. R.
Journal of Drug Education 10(2):101-110, 1980.

The essential classroom dynamics in group process drug and alcohol education are investigated by evaluating 7 years of experience in 17 California high schools. Group process drug education fosters learning about drug and alcohol issues via personal interaction and seeks to affect students' attitudes and drug-taking behavior by promoting introspection. Qualities for effective group leadership in drug education include group counseling skills, openness, a concern for students, and a knowledge of basic pharmacology. The best classroom climate for group process strategies fosters a feeling of security and maximizes respect for the rights and opinions of others. Problems that may arise include breaches of confidentiality, personal discomfort with process techniques, school setting constraints, disruptive students, and discipline and grading considerations. 10 references.

81-0865
Health Education: Focusing on the Video Show.
Graham, J. L.
Health and Social Service Journal (London) 90(4702):948-949, July 18, 1980.

The Forth Valley Health Board is producing and evaluating six videotapes as part of a research project. An analysis of the relevant literature indicated that the content of a tape should be aimed at persons of average or below average literacy and should use familiar language, imperative verbs, and a prefacing commentary. The production of a videotape involves preparation, taping, and editing. Preparation involves coordination of props and graphics, selection of performers, and investigation of copyright laws on music to be used. Once completed, the tape should be viewed and assessed by professionals and patients via written and picture questionnaires and interviews. Videotapes save professionals time and visually present material that can be difficult to present in any other way.

81-0866
Healthy Babies: Chance or Choice? A Peer Education Approach.
March of Dimes--Birth Defects Foundation, White Plains, N.Y.
White Plains, N.Y., the Foundation, 48 p., 19--.

The "Healthy Babies: Chance or Choice?" program is a peer education project that involves teenagers in sharing information with other teenagers to promote healthy behaviors during gestation and adoption of proper child-care techniques. Peer educators and counselors inform adolescents concerning conception, contraception, risks for the teenage mother and her baby, effects of alcohol and drug use, effects of smoking, nutrition during pregnancy, venereal diseases, effects of rubella, and other related topics. Successful methods used by peer educators have included panel discussions, parenting resource centers, rap sessions, alliances with Parent-Teacher Associations, community or school surveys, contests, cooking classes, debates, crossword puzzles, taped music or interviews, audiovisual aids, and media campaigns.

81-0867
Looking In: Exploring One's Personal Health Values.
Read, D. A.
Englewood Cliffs, N. J., Prentice-Hall, 119 p., 1977.

Material is presented for determining an awareness of the self through personal inventory tests, behavioral change sheets, and values clarification exercises. Topics include personal health, consumer health, mental and emotional health, exercise and physical fitness, nutrition, sex and sexuality, drugs, disease, accidents, environmental health, and aging and death. The exercises attempt to force people to think about their behavior and values as a first step in making desired changes.

81-0868
Plaque Control Program: Can It Be Effective?
Roller, N. W.
General Dentistry 27(5):58-61, September-October 1979.

A study involving 20 female dental patients 25-60 years old was designed to assess whether the following interventions motivated patients to control plaque buildup: (1) individualized instruction, (2) multiple instruction sessions, (3) encouragement of active patient participation, (4) minimization of fear, and (5) reinforcement. To be accepted for the study, each participant had to have at least five natural teeth per quadrant, gingival disease manifested by bleeding upon gentle probing, no oral hygiene instruction within 6 months, and no acute dental condition that would require permanent treatment. Five appointments were scheduled during a 2-week period; another appointment was scheduled 2 months after the initial appointment, and patients were recalled with 24-hour notice for an additional unannounced appointment after 6 months. The appointments involved brushing, flossing, and disclosure tablet instruction. A gingival and plaque index was obtained at the initial visit and after 2 weeks, 2 months, and 6 months. Results revealed a significant improvement between the initial gingival and plaque indices and the indices obtained at the end of the 2-week instruction period; the improvement was maintained at the 2-month and 6-month followup. The program, which only requires a total of 60-90 minutes with each patient, could be replicated easily in a dental office. 13 references.

81-0869
Wisconsin's Public Education Network.
Small, I.
Alcohol Health and Research World 5(1):37-38, Fall 1980.

Experiences in Wisconsin indicate that statewide mass media public awareness campaigns can be implemented using only the State's resources. Since 1974, Wisconsin has operated almost a dozen statewide media campaigns, and in 1980 the Wisconsin Association on Alcoholism and Other Drug Abuse won the Prevention Programs Award of the National Council on Alcoholism. The key to Wisconsin's success is a carefully planned network through which informational materials can be disseminated quickly and inexpensively from the State to the local level. The network can be visualized as a pyramid, with statewide administrative units at the top, a seven-member Public Awareness Steering Committee in the middle, and a 60-member Statewide Public Awareness Committee on the bottom. The top level produces, evaluates, and distributes prevention materials; the intermediate level plans the campaigns; the bottom level implements the campaigns. Effective statewide campaigns must have a clear message, an understanding of the audience, and a network for reaching that audience. The steering committee should be small, have carefully defined responsibilities, and include only expert staff members. Specific persons should be assigned to specific media. Following each campaign, feedback should be obtained from local representatives.

81-0870
Healthy Moms Make Healthy Babies: An Educational Guide for the Perinatal Period.
South Carolina Univ., Columbia. Perinatal Curriculum Project.
Columbia, S. C., the University, 165 p., 1978.

A perinatal education guide, developed for public health clinics by the Improved Pregnancy Outcome Project, Bureau of Maternal and Child Care at the University of South Carolina, helps maternity patients (1) exhibit those attitudes and behaviors that contribute to health during pregnancy; (2) develop sufficient knowledge to make informed decisions about prenatal care, family planning, childbirth, and infant care; and (3) demonstrate parenting behavior that enhances growth and development of the child. The curriculum is divided into prenatal education, childbirth education, infant care, and parent education and family planning. Educational objectives were formulated for each of these sections, and an instructional module was developed for each objective to (1) present an overview of content; (2) suggest instructional activities; (3) obtain instructional materials; and (4) develop evaluation criteria.

81-0871
Proto-Analysis of Academic Prevention.
Worden, M.
Journal of Psychedelic Drugs 12(1):75-78, January-March 1980.

Those who design preventive strategies in health education, particularly in alcohol education, should not be hindered by the academic superstition that before a complex multicausal problem can be prevented researchers must have precise knowledge of determinants. Historically, this position is refuted by the efficacy of the "sanitary ideal," which resulted in widespread improvement in health prior to precise knowledge of specific etiologies. Similarly, successful prevention of infectious diseases preceeded the elaboration of the germ theory, and successful prevention of pellagra preceeded full knowledge of the causes of vitamin deficiency. Much of the academic superstition

seems to be based on fear of infringing on economic and political territories valued in Western society. One means of avoiding sensitive political and economic issues associated with alcoholism prevention programs is to fund extensive academic research on prevention. Unfortunately, such academic prevention does not prevent; rather, it continuously waits for more facts to come in and rarely recommends action. 24 references.

81P-0872
Center for Health Games and Simulations.
Sleet, D. A.
San Diego State University, College of Human Services, San Diego, CA 92182
1973 - Continuing.

The Center for Health Games and Simulations in San Diego, California, attempts to encourage the design, development, and evaluation of games and simulations for use in health education. The center purchases all games and simulations relevant to teaching health and safety education; publishes subject bibliographies for individuals interested in using games and simulations in teaching, therapy, research, and planning; disseminates information on the use, design, and evaluation of gaming strategies in health; and serves as a clearinghouse for health games and health game information. Over the past 4 years, the center has collected over 100 commercial health games and approximately 45 student-produced health games in nutrition, human sexuality, fitness, drug abuse, disease, ecology, emotional health, marriage, health care, safety, smoking, consumer health, aging, and reproduction. Users have included teachers, physicians, nurses, crises agencies, social workers, and public health educators. Students in health sciences and saicty at San Diego State University participate in research, evaluation, and design activities at the center. From 1973 to 1978, over 7,000 requests for information were received and processed.

PATIENT EDUCATION

81-0873
Rural Clinics Try Out Patient Education in Four Demo Projects.
Health Care Education 9(1):1, 22, February-March 1980.

Several health care clinics in rural Florida received 2-year funding from the State to conduct patient education programs. The funds will suppport one nutritionist, one health educator, and one nurse in each clinic. Educational programs sponsored or planned by the clinics include a 12-week weight reduction course, health newsletters, a questionnaire survey administered through a newsletter, and classes on diabetes and parenting. So far, only the weight reduction class has met with any success. Though the survey had a return rate of only 22 percent, it is a good indicator of the health concerns that interest the community.

81-0874
Helping Diabetics Learn Control Habits.
Borgatti, R. S.
Patient Care 14(5):120-144, March 15, 1980.

Four aids containing basic treatment instructions for the diabetic have been developed to supplement a comprehensive patient education program. The aids provide fundamental knowledge concerning injecting insulin, rotating insulin injection sites, maintaining a proper diet to prevent hyperglycemia and hypoglycemia, and urine testing. The dietary aid concentrates on diet exchanges.

81-0875
Teaching Patients to Cope With Polymyalgia Rheumatica.
Brassell, M. P.
Nursing 8(5):22, 24, May 1978.

Polymyalgia rheumatica (PR) is a type of muscular rheumatism usually affecting persons 50-60 years old, but affecting younger persons in rare instances. PR patients complain of headaches or painful areas at the top of the cranium, and muscular pain and stiffness in the back, neck, shoulder, pelvic girdle, and upper arms and thighs. Patients must be taught to balance exercise with rest and to take medication precisely as directed. Patients must be reminded that the disease can only be controlled, not cured. Because anxiety and depression often accompany PR, the patient needs as much emotional support as possible.

81-0876
An Evaluation of a Program for Teaching Clinic Patients the Rationale of Their Peptic Ulcer Regimen.
Caron, H. S. and Roth, H. P.
Health Education Monographs 5(1):25-49, Spring 1977.

A 2-year study involving 160 patients affected by recent acute attacks of peptic ulcers examined the effectiveness of teaching clinic patients about complex medical concepts related to the rationale of antacid therapy. Those

who already knew about the rationale were excluded from the study, and the remaining patients were divided into three groups, one that was taught the rationale, one that was taught other materials, and one that acted as a control. Patient learning was assessed through 5 different instruments. Teaching proved effective when basic concepts were identified and taught, when important misconceptions were eliminated, and when patients' attention was maintained and their progress monitored by means of the Socratic method. The key facts were acquired by 85 percent of the patients within four sessions. However, application of the learned concepts to new problems varied with the intelligence of the patient, and certain misconceptions could not be eliminated by the teaching process. 19 references.

81-0877
Health and Patient Education at the Arizona Health Sciences Center (Editorial).
Chenet, L. L.; Johns, L. P.; and Kettel, L. J.
Arizona Medicine 37(6):431-432, June 1980.

The Family Practice Office of Arizona's Department of Family and Community Medicine has a comprehensive patient education program that includes a Patient Education Center and library, a component for development of new patient education materials and programs, and a component for patient education training for family practice residents and undergraduate medical students. The Patient Education Center provides individual and group outpatient counseling for patients referred for education by practitioners. A library of videotapes, slide-tape programs, and pamphlets is also available. The patient education committee at the center includes family practice residents, medical students, health education staff, and representatives from clinical pharmacy and social services. The Biomedical Communications Division is involved in the development of training and education programs for medical students, and provides production support services for the health education programs of individual departments at the college of medicine and the university hospital. Education services available to patients within the university hospital include instructional programs on proper nutrition, urine testing, medication doses, identification of signs of potential health risks, prenatal care, and coronary care. Finally, the center sponsors a community health education program, "Project Well Aware About Health."

81-0878
Staff Manuals for Teaching Patients.
Chewning, B. and Betz, E.
Journal of the American Dietetic Association 77(4):460-462, October 1980.

A series of manuals (hypertension, diabetes, rheumatoid arthritis, and chronic obstructive pulmonary disease) for hospital staff published by the American Hospital Association encourages the participation of nutritionists and other health professionals on patient education teams. The hypertension manual, which was field tested at six hopitals, indicates that the nutritionist and the nurse should meet regularly to discuss learning priorities for dietary management and facilitation of each other's roles. All manuals suggest that medical staff and nutritionists discuss mechanisms for nutritional referral of patients, the possibility of developing standing doctor's orders for nutrition education, and means of professional reinforcement and evaluation of patient knowledge regarding nutrition. Chapters deal with disease processes, medical management, and psychosocial issues. Each chapter opens with a list of learning objectives and includes study questions, exercises, and resource materials. Each manual also outlines means of promoting patient and family education and includes chapters on the teaching-learning process and on means of organizing patient education in a hospital setting using a team approach.

81-0879
Advertising or Education: Alternative Models for Patient Education.
Clarke, W. D.
Journal of Audiovisual Media in Medicine (London) 3(1):21-22, 1980.

A poster-changing machine containing dramatic illustrations accompanied by short messages was tested on 112 patients in a general practitioner's clinic. Each patient was exposed to the presentation about four times during the average 12-minute stay in the waiting room. A knowledge quiz was administered to the patients and to a control group of 99 persons recruited at a local shopping center. Evaluation indicated that, in every case, the clinic group's scores were significantly higher than those of the control group. Moreover, no patient ever complained about the machine; patients could be observed watching the machine with interest; and many patients were stimulated to ask their doctor further questions. From the standpoint of cost and efficiency, the device proved inexpensive and effective.

81-0880
Three Steps to Better Patient Teaching.
Cohen, N. H.
Nursing (Horsham) 10(2):72, 74, February 1980.

A systematic approach to patient education for the diabetic requires the nurse to assess the setting and patient before determining educational content. The setting includes the type of hospital, the type of hospital unit, the surrounding community, and the available resources. Assessment of the patient involves evaluating the patient's general knowledge, beliefs, perceptions, goals, abilities, and learning barriers. On the basis of the evaluation, the educator should formulate instructional content that increases the patient's knowledge and promotes compliance to the recommended treatment. Once teaching is completed, the patient's retention of the material and the likelihood that the patient will comply with the prescribed regimen can be determined by followup questions. A similar structure can be applied to groups. 7 references.

81-0881
Patient Fact Sheets: Nurses Demonstrate Patient Advocacy.
Danielson, C. D., et al.
Journal of the New York State Nurses Association 11(2):5-8, June 1980.

The Council of Nursing Practitioners, an organization of registered nurses at the Carthage Area Hospital in New York, has developed numerous means of improving nursing practice within the hospital, including the development of patient fact sheets. The fact sheets, which are issued to patients who are to be subjects of X-rays or sigmoidoscopy, are explanations of the procedures written in lay language. After approval by the Director of Nursing Service, the X-ray department, and medical staff, the fact sheets were successfully integrated into normal hospital procedures.

81-0882
Patient Education Reimbursement.
Davis, W. G.
Group Practice 29(3):8-10, March 1980.

Since 1973, the American Group Practice Association (AGPA) has been involved in a cooperative effort with Core Communications in Health and the Warner-Lambert pharmaceutical company to develop an organized system of patient education. In 1974, AGPA held the National Forum on Patient Education Reimbursement. Issues discussed at the forum included demands by patients for health education, reluctance of third-party payers to provide reimbursement for patient education and for allied health services not provided in inpatient settings, and malpractice suits. Though patients have responded well to patient education efforts, physicians have demonstrated little enthusiasm, even though at times education can help alleviate patients' stress. Moreover, nurses, pharmacists, and other professional adjuncts to the physician are often of little help to patients. Hence, the patient educator has responsibility for health education. AGPA guidelines for patient education reimbursement policies suggest that (1) patient education efforts be cooperative ventures involving both professionals and patients, (2) patient education consist of planned efforts, (3) patient education be available only through a physician's prescription, (4) services be appropriate to the immediate needs of the patient, (5) services be provided under the direction of an education committee, and (6) services be subject to quality reviews.

81-0883
Adaptive Rehabilitation in Cancer: A Program to Improve Quality of Survival.
Dietz, J. H., Jr.
Postgraduate Medicine 68(1):145-147, 150-151, 153, July 1980.

A program for adaptive rehabilitation of cancer patients is described. In order to improve the quality of survival regardless of life expectancy, the program emphasizes tolerance of the disease and elimination of unrealistic expectations of restoration of good health. Components include (1) goal-directed management appropriate to the patient's need, from prevention or restoration to support or palliation; (2) activities to interest, motivate, and distract the patient that are directed toward specific exercise goals; (3) measures to counteract the disabilities associated with cancer and its treatment, including coordination training, assistance in restoring range of motion, appropriate bracing, instruction in protection from trauma and possible self-injury, and behavioral training to reduce pain; (4) specific rehabilitation measures for the area affected by the disease; and (5) psychosocial and vocational guidance to counter anxiety, stress, and withdrawal. 15 references.

81-0884
The Diabetes Educator's Role in Teaching the Diabetic Patient.
Dudley, J. D.
Diabetes Care 3(1):127-133, January-February 1980.

Diabetes educators have become a necessary, cost-effective addition to the health care team. The role of the nurse-educator in clinical practice and in hospital teams is a new approach to improving the quality of patient education. The nurse-educator has specific responsibilities in the evaluation of each diabetic patient. The nurse must assess

not only the individual's knowledge about the condition and related educational needs, but also the patient's readiness to learn. Whereas the physician's contact time with each diabetic patient is limited, the nurse-educator has time to spend with the patient and family. The nurse-educator must be skilled in the teaching-learning process, have a good understanding of diabetes, have the capability to evaluate teaching effectiveness, and interpret current research for the patient and encourage the patient to become involved.

81-0885
The Nurse Clinician: A Teaching Model for Postpartum Units.
Dungy, C. I.; Brown, N.; Krantz, M.; and Orr, D. P.
Journal of Medical Education 54(6):507-509, June 1979.

A nurse-clinician position was created in the Department of Pediatrics at the University of California Medical Center to (1) help remedy the inability for bonding between the mother in the postpartum section and the infant in the nursery, (2) guarantee parenting education for the predominantly Hispanic population, (3) route discharged postpartum patients into community agencies for follow-up services, and (4) bridge the communication and cultural gap between faculty and staff on the one hand and patients on the other. The position requires special psychosocial skills and competence in health education. The nurse develops interdisciplinary approaches to patient care, demonstrates via role modeling the importance of continuing education and teamwork between nursing and medical staffs, coordinates patient education, expands in-service training, facilitates delivery of services to patients, and acts as liaison among all affected parties. The nurse chosen to perform these duties has functioned successfully in the assigned roles.

81-0886
A New Approach to Diet for Diabetes.
Eno, J.
Journal of the Canadian Dietetic Association (Toronto) 40(2):118-122, April 1979.

Effective diet counseling for diabetics requires (1) development of a personal rapport with the client, (2) elicitation of a complete history of the client's eating habits and activity patterns, and (3) explanation to the client of the reasons for each requested dietary change. The National Diet Simplification Task Force of the Canadian Diabetic Association (CDA) is developing a poster and booklet for teaching diabetic persons and their families about diet. The project has involved collection of data on simplified diets used throughout North America, formulation of a diet poster, submission of the poster to peer evaluators, and implementation of field tests with diabetics. The resulting simplified diet should show all information necessary to plan a day's meals; require only a single sheet of paper; name and illustrate the foods; use a minimum of measures; and provide a practical aid for persons with vision, reading, or comprehension difficulties. 1 reference.

81-0887
Reducing Preoperative Anxiety in Children: Information Versus Emotional Support.
Fassler, D.
Patient Counselling and Health Education 2(3):130-134, 1980.

A study of 45 children 6-12 years old who had been admitted to a hospital pediatric ward for minor surgery explored the relative effectiveness of interventions designed to help children cope with the emotional trauma of hospitalization. The three groups into which the children were placed included one in which the children received information with supportive explanations and discussions, one in which the children received only emotional support, and one in which the children received no planned intervention. Anxiety was measured by a Manifest Anxiety Test based on the standard Children's Manifest Anxiety Test and an Anxiety Pictures Test involving 40 ink-blot drawings. A three-way analysis of variance was performed on each of the anxiety measures, with sex, age, and the intervention conditions as the independent variables. The group that received both information and emotional support scored significantly lower on both anxiety tests than did the other two groups, and the group that received emotional support only scored significantly lower on the ink-blot test than did the group that received no intervention. (Low scores on the tests signify low levels of anxiety.) Other findings suggest that the ink-blot test measures transitory anxiety levels, while the Manifest Anxiety Test measures deep-seated trait anxiety. All such programs aimed at children should include distinct emotional components. 11 references.

81-0888
Preparation of Adult Patients for Cardiac Catheterization and Coronary Cineangiography.
Finesilver, C.
International Journal of Nursing Studies (Oxford) 15(4):211-221, 1978.

A study to develop and test a preparatory intervention designed to decrease distress before, during, and after cardiac catheterization is discussed. The intervention consisted of (1) assessment of sociodemographic and illness-related patient characteristics to determine their effects on patient welfare; (2) provision of information to familiarize the patient with the events occurring before, during, and after the catheterization; (3) descriptions of cardiac anatomy, physiology, and pathophysiology pertinent to the patient's condition; (4) familiarization of the patient with things that would be requested during the catheterization procedure; and (5) provision of emotional support and reassurance. The Spielberger Trait Anxiety Inventory and the Mood Adjective Check List were used to evaluate each patient's emotional and psychological condition. The experiental group did not report higher positive or lower negative moods than did the control group before or after catheterization, nor were they less distressed by typical sensations of catheterization. However, the experimental group was more satisfied with the information they received than was the control group. 16 references.

81-0889
Make Diabetes Control a Family Affair.
Fuller, E., ed.
Patient Care 14(5):168-204, March 15, 1980.

A cross section of personal experiences of diabetics' families and of the diabetics themselves suggests means of dealing with the family stresses created by the presence of a diabetic child or parent. Cooperation by the family, or any person who influences the diabetic, is essential in the control of the diabetic's condition. The physician or health educator should involve the patient and the family in the patient education process immediately after diagnosis. The professional should allay possible guilt feelings on the part of parents, explain the reasons for the patient's symptoms, outline a rationale for the prescribed treatment plan, and recommend a basic diabetes manual. With adolescent patients, the physician should be sure to recognize possible use of the disease as a weapon in the rebellion against parents and to discuss marriage and parenthood before the patient is ready to marry. Finally, the physician should urge the patient and the family to attend a hospital education program, alert the patient and family of what to expect in the development of the disease, and encourage compliance with the therapeutic regimen.

81-0890
Why Patients Learn... Why Patients Fail...: Factors That Influence Patient Compliance.
Gaines, H. P.
Journal of Practical Nursing 29(9):22-24, 39, September 1979.

Diabetic patients will not achieve total compliance with diabetic regimens unless all three stages of cognitive, behavioral, and attitudinal change have taken place. The cognitive stage will be determined by the patient's mental orientation, ability to understand content, and ability to recall. The health educator can assess patients' cognitive ability by reviewing the medical chart, administering intelligence tests, and following teaching sessions with discussions to determine what the patients have learned and are able to recall. To encourage behavioral changes, family members should be included in teaching sessions to help the patient maintain skills (proper use of insulin and preparation of appropriate diets). Attitudinal changes are more complex and difficult to achieve. Success depends largely on the instructor's knowledge and consideration of patient personality, psychological makeup, ethnic background, economic level, and environment. 9 references.

81-0891
Helpful Tips You Can Give Your Patients With Parkinson's Disease.
Gresh, C.
Nursing (Horsham) 10(1):26-33, January 1980.

The most important educational duty of the nurse treating Parkinson patients is helping them deal with the side effects of levodopa drug therapy. As doses of the drug increase, the patient usually experiences anorexia or nausea and vomiting. To prevent the patient from ceasing to take the medication due to the side effects, the nurse should (1) explain that these effects disappear after a few months, (2) encourage the patient to take the medication after meals or with an antacid, (3) notify the doctor if the effects seriously impair the patient's eating habits, (4) explain that hypotension is common during the first weeks of levodopa treatment, (5) encourage the patient to get up slowly, (6) provide elastic stockings to reduce the severity of hypotension, and (7) monitor blood pressure every 4 hours. Other side effects that the patient must be informed of include darkened urine, perspiration, or increased saliva; cardiac arrhythmias; agitation; insomnia; confusion; and involuntary movements. The patient should also be educated concerning the potential progress of the disease, dietary and exercise recommendations, outpatient therapy, and the need to see a public health nurse periodically. 4 references.

81-0892
Helping the Diabetic Manage His Self-Care.
Guthrie, D.
Nursing (Horsham) 10(2):57-64, February 1980.

Due to the high level of patient participation in the management of diabetes, patient education programs for diabetics should be thorough. The patient should be given an instructional pamphlet for insulin-dependent or noninsulin-dependent regimes, depending on the patient's condition. This literature should explain the role of insulin in the body, hyperglycemia, hypoglycemia, factors that affect blood glucose levels, foot care, identification bracelets, insulin injection, and urine testing. The educator should keep an assessment sheet that lists all topics that should be discussed with the patient and the patient's family. The sheet should have space for dated entries concerning the topic covered, the responsiveness and apparent understanding of the patient and the family, and general comments.

81-0893
Tune-In to Prime Time Health Care.
Howie, H.
Health Care (Don Mills) 22(3):20-21, 23-24, March 1980.

An increasing number of hospitals are using television to educate their patients, employees, and community members about the hospital, preventive medicine, and ways of coping with disease. The number of hospitals in the United States that have departments to coordinate inpatient education programs rose by 65 percent between 1975 and 1978, and the number of hospitals using videocassettes or closed-circuit television in patient education programs rose by 160 percent. In addition to patients, television programming has been aimed at employees, nonpatient users, and businesses. Some Canadian hospitals offer cable extensions to the community and satellite extensions to outlying regions. Although no studies on patient utilization or information retention have been conducted, it appears that patients who watch the programs feel better about the hospital and the quality of information they receive than patients who do not. Programming frees staff from general educational tasks, links hospitals, allows delivery of specialized services to outlying hospitals, and generally proves cost effective.

81-0894
Diabetes: A Redesign for Life.
Hunt, B.
West Hartford, Conn., American Diabetes Association, Connecticut Affiliate, Inc., 82 p., October 1980.

Guidelines for diabetic patients are offered to allow them to understand and control their disease. Topics include use and storage of carbohydrates, effects of ingestion of carbohydrates by the diabetic, categories of diabetes, the role of heredity in diabetes, diagnosis of diabetes, major complications of diabetes, exercise, diet, medication, urine testing, report of urine tests, routine blood testing, symptoms of hypoglycemia and hyperglycemia, foot care, skin care, general care, identification bracelets and tags, daily care instruction, instructions for those receiving insulin, instruction for those receiving oral medication, sources of education concerning diabetes, and future issues of interest to the diabetic.

81-0895
Effects of Preoperative Teaching Upon Patients With Differing Modes of Response To Threatening Stimuli.
Kinney, M. R.
International Journal of Nursing Studies (Oxford) 14(1):49-59, 1977.

Male candidates for cardiac surgery were studied to determine if there is a difference in the anxiety level of repressors, sensitizers, and neutrals before and after preoperative teaching. Repressors are persons who avoid, deny, and repress threatening feelings. Sensitizers approach threatening stimuli by employing intellectualization, obsessive behaviors, and worry. To determine autonomic stimulation, measurements were made of systolic and diastolic blood pressure, heart rate, circulating lymphocytes, and circulating eosinophils. In addition, the patients completed the State-Trait Anxiety Inventory (STAI) form consisting of 20 statements requiring patients to indicate their feelings at a particular moment. Immediately following the patient and family teaching period, and again 1 and 4 hours after the education session, patients' blood pressures and heart rates were determined. Blood samples were taken and the STAI form was administered again. Results indicated that although repressors, sensitizers, and neutrals differed in typical mode of response to a perceived threat, all experienced some decrease in anxiety level following preoperative teaching. The three groups also produced lower, though not significantly lower, scores on the STAI following the teaching session. Lymphocyte counts were higher for each group after the teaching, indicating decreased autonomic stimulation. 9 references.

81-0896
A Computerized Diet Survey for Dental Patients.
Koerber, L. G. and Dray, J.
Journal of the Indiana Dental Association 58(5):26-29, September-October 1979.

The Indiana University School of Dentistry has modified a computerized diet survey program developed by the

School of Dentistry at the University of Missouri. The program is used in the dental hygiene clinic and in a chemistry and nutrition course for dental students. The data recording method, taught to each patient during a 15-minute interview with a dental student, involves a 5-day food intake record and a 24-hour intake recall record covering time of intake, food type and name, style of preparation, and serving size. The food intake record is returned, coded, keypunched onto cards, and processed by the computer, which produces a seven-page printout. The printout assists the student in diet counseling, impresses the patient with a high level of organization, and provides a permanent record to give the patient as a reinforcement for dietary recommendations. Though the lengthy coding and handling process results in a turnaround time of 10-14 days, the program has been effective as a focus for dietary counseling.

81-0897
Prescription Drug Use and Patient Education--The Critical Role of the Pharmacist.
Lee, P. R.
American Journal of Pharmaceutical Education 43(4):354-357, November-December 1979.

Pharmacists can play a key role in educating patients and physicians about prescription drugs and thus can help correct many problems associated with the misuse of these drugs. Changes in the morbidity rate do not account for the rapid increase in drug use over the past 20 years. The escalation in drug use is particularly alarming with respect to antibiotics, psychoactive drugs, and estrogen. Recent studies of some of the most frequently prescribed drugs, including psychotropic drugs, estrogens, and anti-infectives, indicate that these drugs are often prescribed inappropriately by physicians. Furthermore, a review of 185 studies reveals that, depending on the study, prescription compliance rates for patients with acute illnesses can vary from 18 to 89 percent. For long-term therapy, the average rate was 54 percent, but only 33 percent of the patients took all prescribed medication. To correct this situation, the physician must take greater responsibility as a communicator of prescription information to the patient, the pharmacist must work to reduce the irrational use of over-the-counter and prescription drugs by advising and counseling the patient, and the patient must be given patient package inserts with drugs for which such inserts have been formulated. 23 references.

81-0898
Effect of a Teaching Program on Knowledge and Compliance of Cardiac Patients.
Linde, B. J. and Janz, N. M.
Nursing Research 28(5):282-286, September-October 1979.

Thirty valve replacement surgery patients and 18 artery bypass surgery patients were included in a study designed to look at the effect of a comprehensive teaching program on patient knowledge and compliance. Twenty-five patients were taught by clinical specialists with master's degrees, and 23 were taught by nurses without master's degrees. Measurements of knowledge and compliance were obtained preoperatively, at discharge, and during the first two postoperative visits. Findings reveal significant changes in knowledge scores from the preoperative test to the discharge test and stability in most scores from discharge to both postoperative visits. Compliance percentages were significantly higher than those reported for cardiac patients in a previous study. Patients taught by nurses with master's degrees had significantly higher test scores at discharge than did patients taught by nurses without master's degrees. Further studies are needed to determine whether the difference in scores involved knowledge essential for the patients' well-being. Although nurses can design, implement, and evaluate patient education programs, nurses with master's degrees are highly recommended to develop and coordinate them. 20 references.

81-0899
Take a Systematic Approach to Patient Education Programming.
Longe, M. E. and Elliot, S.
Cross-Reference on Human Resources Management 10(5):4-5, September-October 1980.

The diversity of patient educators' definitions of patient education, perceptions of hospitals, educational and work experiences, and skills in the use of media demand a systematic approach for developing instructional plans for patients. A four-step structure to such an approach involves planning, development, implementation, and evaluation. The steps within this structure followed by the Rehabilitation Services Unit of Edward W. Sparrow Hospital in Lansing, Michigan, in developing a spinal cord injury education program included definition of the problem, documentation of the need for patient education, review of the literature, review of possible program alternatives, specification of program content, translation of the materials into instructional objectives, formulation of the information into a sequence, and selection of the most appropriate method of delivery. The final plan for the spinal cord injury education program included 10 videotaped segments that could be viewed at bedside or in a small conference room by the patient, the family, or both. A leader's guide was provided to ensure program con-

tinuity, and a workbook for the patient and the family provided information on community resources. The patient educator coordinated these materials.

81-0900
Preop Teaching Helps.
McConnell, E. A.
Nursing (Horsham) 10(3):90-92, March 1980.

Preprinted checklists that enable preoperative nurses to record patient teaching can lessen the time spent on these activities and increase time available to spend with the patient. Although such checklists are not available from suppliers, they may be formulated by nursing departments. Companies which produce preoperative teaching aids include Channing L. Bete Company of Greenfield, Massachusetts; Robert J. Brady Company of Bowie, Maryland; and Milner-Fenwick of Timonium, Maryland.

81-0901
Patient Knowledge and Compliance With Medication Instructions.
McKercher, P. L. and Rucker, T. D.
Journal of the American Pharmaceutical Association NS17(5):282-286, 291, May 1977.

Sixty elderly clinic outpatients averaging 60 years of age were interviewed to determine the relationship between compliance behavior and patient knowledge (measured by years of education, medical quiz scores, and verbal identification of medications). Patients with high levels of knowledge had a greater incidence of noncompliance with prescribed medications; the ability to verbally identify medications and the prescription instructions was the most significant indicator of noncompliance. These findings challenge the view that knowledge of drug names and prescription instructions is an accurate predictor of patient compliance. 35 references.

81-0902
Parents' and Childrens' Reactions Toward Impending Hospitalization for Surgery.
Meng, A. L.
Maternal-Child Nursing Journal 9(2):83-98, Summer 1980.

An evaluative study involving 100 elective surgical candidates 4-10 years old and their parents was designed to measure the effects of a preadmission program that consisted of a videotaped puppet show. The subjects, who were treated at a 750-bed medical center in upstate New York, were randomly assigned to an experimental group, which viewed the show, or to a control group. A subgroup within the experimental group was given a tour of the school-age and infant-toddler units. Parents were interviewed at the time of admission to obtain data regarding their reaction to the preparation program. Parents were asked to describe any preparation they had initiated with their child, the effect any recent hospitalization of a family member or close friend had on the child, the child's emotional response to the impending hospitalization, and the hospital-related questions that the child initiated. Content analysis of the parents' responses indicated that significantly more parents in the experimental group discussed the hospitalization with their children and remembered specific discussion content; that experiences of friends and family members who had been recently hospitalized were perceived as positive by all groups; that children in all groups were curious about their hospitalization; and that parental anxiety contributed to anxiety in the children. Thus, it seems that the preadmission program stimulated parents to prepare their children for the upcoming hospitalization. 2 references.

81-0903
Pseudocommunication With Patients.
Mercer, L.
Nursing (Horsham) 10(2):105-108, February 1980.

Nurses who expect to be successful in altering their patients' behaviors and attitudes must be able to establish good interpersonal relationships that elicit more than cliche responses from the patients. Small talk should be avoided whenever possible, and sharing emotional reactions with patients can be helpful. Although directive communication is necessary in patient teaching and crisis intervention, it should be avoided when encouraging self-expression in a patient.

81-0904
Sources of Programming for Patient TV Systems.
Null, J.
Texas Hospitals 36(3):10-12, August 1980.

There are several sources of programming for patient closed-circuit television systems that offer services at no cost or at a nominal cost. These sources include Modern Talking Pictures, which distributes 16mm films and videotapes for firms and nonprofit organizations; numerous Federal agencies, including the Social Security Administration, the Department of Energy, the National Park Service, and the National Air and Space Administration; the Shell, Exxon, Continental, and Phillips Petroleum companies; insurance companies; drug companies; and students

who need field experience for their television or communications courses. Listings are available from film catalogs produced by Esselte Cideo and the Health Educators Resource Catalogue, and from trade magazines. Another source could be each institution's current inventory of audiovisual materials on other formats that can be transferred to video with relative ease. For all sources, users must be scrupulous in getting written permission to use films. No film should be used without adequate review by responsible persons, and recognition should be given to sources, particularly sources of free materials. 10 references.

81-0905
An Appeal to Examiners of the Learning Process (Editorial).
Peterson, H.
Patient Care 14(5):11,204, March 15, 1980.

Primary care physicians must reevaluate the traditional belief that diabetics cannot be taught to care for themselves. Physiological discoveries, oral hypoglycemics, refined laboratory techniques, and the resurgence of nutrition's importance in medicine enable the physician to advise the diabetic far better than was possible 20 years ago. Each individual passes through several chronological stages characterized by varying degrees of receptiveness to teaching. The physician should understand and take advantage of the opportunities of each of these stages.

81-0906
The Experience of an Academic as Care Giver: Implications for Education.
Roach, M. S.
Death Education 2(1-2):99-111, Spring-Summer 1978.

The experience of a nurse-educator who participated in a 1-month course in the care of terminally ill and dying patients at St. Christopher's Hospice in London, England, is examined in terms of the implications for death education. St. Christopher's is a Christian medical foundation, funded partly through donations and grants, that is (1) helping patients and their families deal with terminal illness, (2) conducting a series of psychosocial studies of the needs of mortally ill patients, and (3) providing multidisciplinary teaching experiences in thanatology. The hospice, which has firm links in policy and practice with the National Health Service, is open to all regardless of their ability to pay. Participants in the month-long course participate in ward duties, discussion sessions, and viewing of films. The ward program for the dying uses no standard hospital equipment, and the healthy and the dying live in the same integrated community setting. The success of the hospice indicates the need for inclusion of death and dying courses in standard curricula, opportunities for professionals to practice in a hospice setting, and development of hypothetical models to introduce students to the problems of the dying. 5 references.

81-0907
Pilot Study of Discussion Groups for "Worried Well" Patients in an Ambulatory Care Setting.
Ross, H. S.; Collen, F. B.; and Soghikian, K.
Health Education Monographs 5(1):51-61, Spring 1977.

Two pilot educational discussion group programs for "worried well" (functionally ill or psychosomatic) patients at the Kaiser-Permanente Medical Center at Oakland, California, were designed to demonstrate the use of an educational method to induce attitude and behavior changes in these patients. The planning team consisted of an internist, a psychiatrist, a nurse-educator, and a health educator. The first study group consisted of five female patients, the second of two males and six females. The groups met weekly for 6 weeks. It was hoped that this scheme would reduce utilization of more expensive physician resources. Preliminary findings indicate that 50 percent of the patients reduced the number of their physician visits, and 60 percent perceived the experience as helpful. Five of eight patients followed for 12 months after termination of the group meetings had continued reducing their utilization of medical resources. Future studies should be designed to examine effects of similar programs over a longer followup period, effects of applying the model to other patient populations, the cost effectiveness of the approach, and the efficacy of health educators as group facilitators. 19 references.

81-0908
Intervention to Improve Compliance With Pediatric Anticonvulsant Therapy.
Shope, J. T.
Patient Counselling and Health Education 2(3):135-141, 1980.

A study involving 201 pediatric seizure patients and their parents treated by the Pediatric Seizure Clinic of Children's Hospital of Michigan investigated compliance with prescribed therapy and the efficacy of an education program in reinforcing compliance. The instruments used included a structured interview and a laboratory test to measure the amount of anticonvulsant medication in the patient's serum. The study used a pre- and posttest design with an experimental educational intervention involving

28 mothers of noncompliant children and a control group of 39 mothers of noncompliant children. The experimental group participated in two group discussion meetings facilitated by a social worker. The control group received no special treatment aside from the interview and blood test on the children. Followup interviews and lab tests were done at regularly scheduled clinic visits. Results of the followup, which included a 12-item knowledge test, indicated that those mothers who attended the group discussions scored significantly higher on subsequent compliance and knowledge measures. Mothers in the experimental group who were contacted by phone and by mail, but who did not attend the meetings, scored higher on both measures than did those in the control group. Thus, it appears either group meetings or less personalized forms of contact can improve compliance, though the latter is somewhat less effective. 20 references.

81-0909
Maximizing Patient Compliance by Shaping Attitudes of Self-Directed Health Care.
Talkington, D. R.
Journal of Family Practice 6(3):591-595, March 1978.

A study was conducted to develop an efficient and practical procedure to maximize patient compliance and to shape attitudes and habits of self-directed health care and maintenance. Factors related to high patient compliance were identified and compliance categories were developed. One hundred and eighty-two patients comprised the experimental group, and 156 acted as controls. Compliance rates were higher in all categories for experimental patients, but compliance rates in both groups were higher than those cited in the literature. Experimental group patients reacted more favorably to the personal interaction they received than to other procedural aspects. Findings suggest that increased compliance will result if greater emphasis is placed on building a partnership with the patient, rather than on making compliance itself the major goal. 7 references.

81-0910
Instructing Patients in Physiotherapy: An Example Using Three Methods.
Wright, V.; Hopkins, R.; and Jackson, M.
Rheumatology and Rehabilitation (London) 19(2):91-94, May 1980.

Fifty-two patients treated for rheumatoid arthritis of the hands at the Rheumatism Clinic of the Leeds (England) General Infirmary were instructed in the use of wax baths and hand exercises at home. The patients were randomly assigned to a group that received handouts on the baths and exercises, a group instructed in the treatment by a physiotherapist, or a group instructed at the physiotherapy department and brought back 7-8 days later for reinforcement. The handouts were given to all three groups. The patients were assessed during personal interviews 4 weeks after the initial interview. Results of the assessments indicated that the most effective method of instruction involved instruction within the physiotherapy department. The least effective method was to rely on the handout alone. Many patients were reluctant to attend the second session of instruction, and those who did grasped no more than those who had attended only once. 3 references.

81P-0911
Getting Started Aide Program.
Cosgrove, J.
Becton Dickinson Consumer Products, P.O. Box 5000, Rochelle Park, NJ 07662
Continuing.

The Getting Started Aide Program distributes teaching aids used for instructing the newly diagnosed diabetic. The teaching aids are distributed by a consumer products corporation and include a patient teaching kit, an audiovisual "getting started" kit, and a patient take-home kit. The patient teaching kit includes a Spanish or English language cassette, a follow-along book, and a patient take-home book. The take-home kit includes product information, a take-home book, product literature and coupons, and insulin syringe samples. The "getting started" kit consists of 35mm slides, synchronized sound cassettes, suggested lesson plans for the instructor, and samples of available patient literature for reinforcing the lessons. The program is divided into three 1-hour modules. The take-home kits are distributed free of charge; the audiovisual program and teaching kits must be purchased.

81P-0912
Helping Hand Health Center.
Johnson, E.
506 West Seventh Street, St. Paul, MN 55102
1971 - Continuing.

The Helping Hand Health Center promotes self-help medical care and disease prevention by educating patients in a clinical setting. Services include individualized patient teaching, placement of displays and educational bulletin boards throughout the center, distribution of 50 individually tailored instruction sheets addressing specific health problems, and self-care outreach seminars taught by center nurses at community centers and schools. Services are available to the entire city. Each year, the center treats

about 10,000 low-income patients who pay according to their income and ability. The center is staffed by 9 full-time nurses and 10 part-time doctors as well as part-time nurses and other personnel. The center coordinates its activities with local hospitals, health maintenance organizations, insurance companies, and other institutions. Forty-five percent of the center's funding comes from patient fees, and city, county, and private sources provide the balance.

81P-0913
Hunterdon Medical Center Patient Health Education.
Hunterdon Medical Center, Route 31, Flemington, NJ 08822
Continuing.

A series of programs for health education is offered to interested community groups, individuals, and patients. Programs available to families or individuals for a fee include educational programs for diabetics and their families, screening, and parenting education. Programs available at no charge to community groups provide education on cancer risk factors, coronary risk factors, breast self-examination, convulsive disorders, hypertension, stress management, venereal disease, body mechanics, personal health habits, allergies, contamination, good health and the aging process, early childhood development, child abuse, childhood health problems, hyperactive children, mental health and schoolchildren, and teenage alcoholism. Inpatient programs are directed at patients with problems related to cardiac diseases, diabetes, anticoagulant diseases, ostomy, and other health problems that physicians may consider important. Noncontinuous programs include a Pap smear screening and education event and six sessions in consumer education. The program has also initiated a health information telephone service, produced a resource directory for health services in the county, and sponsored a self-help group for cardiac patients. The program maintains consulting liaisons with five area hospitals and participates in screening programs in cooperation with numerous organizations such as the American Cancer Society, the Delaware Valley Lung Association, and the American Red Cross. Evaluation statistics are kept on all programs.

PROFESSIONAL EDUCATION AND TRAINING

81-0914
AAHE Directory of Institutions Offering Specialization in Undergraduate and Graduate Professional Preparation Programs in Health Education. 1979 Edition.
Health Education 9(6):35-43, November-December 1978.

Institutions offering specialization in undergraduate and graduate professional preparation programs in health education are listed. The degree offered, address, and the name of the contact person are also provided.

81-0915
The Dental Health Education Experiment at St. Joseph Hospital.
du Fault, M. L.
Journal of Hospital Dental Practice 13(3):94-95, 1979.

In early 1978, the University of New Mexico Dental Program and the St. Joseph Hospital cooperatively initiated an experimental field experience in patient education for dental hygiene students. The program included weekly seminars involving a participating student and a coordinator, bedside dental health education on the medical floor, dental health education to patients in rehabilitation, and limited sessions with professional staff to provide them inservice training. Twenty-eight patients were referred to the student for dental health education, though only 23 patients received dental health education. Time spent with each patient ranged from 2 to 15 minutes. The program was hindered by the fact that hospital schedules often conflicted with the needs of the educator. The most significant index of program success was the hospital's invitation to the university to continue its affiliation with the institution, and its recommendation to broaden the base of the program by including more patients.

81-0916
Teacher Training Through the National Childbirth Trust.
Gillett, J.
Midwife, Health Visitor and Community Nurse (London) 16(9):380-381, September 1980.

Since its inception in 1952, the National Childbirth Trust (NCT), which is a voluntary charitable organization, has explored ways of preparing couples for childbirth and of supporting them as they raise their families. The teacher of a childbirth course should have professional knowledge

of the physiotherapist, midwife, and health visitor, as well as a knowledge of psychology, group dynamics, language, relaxation techniques, the father's part in labor, sex during pregnancy and the puerperium, problems of the underprivileged, and the feelings of the mother during gestation and birth and after the birth of the baby. In 1978, the NCT provided 8,900 women and 2,353 couples with childbirth education and certified 61 teachers. NCT teacher training includes extensive reading, researching, and writing as directed by the tutor, participating in two complete sets of classes from two separate teachers, attending course method and planning seminars, meeting with the tutor, and submitting a syllabus and an essay on a specified subject to a panel of teachers. The NCT provides many continuing education experiences once the teacher has been qualified. 7 references.

81-0917
You, Youth, and Prevention: Trainer Manual.
National Center for Alcohol Education, Arlington, Va.
Rockville, Md., National Institute on Alcohol Abuse and Alcoholism (DHEW, ADAMHA) (DHEW Publication No. (ADM)78-649), 102 p., 1979.
Available from: GPO; Stock No. 017-024-00898-2.

A training model developed by the National Center for Alcohol Education, originally designed to meet the needs of alcoholism service workers as identified in data gathered by the Area Alcohol Education and Training Programs, is presented for use by health educators. The manual provides guidelines for exploring attitudes and developing pertinent skills. In four sessions, trainees explore abuse prevention and learn to improve communication skills pertinent to addressing young audiences, to select a problem focus, and to select a prevention strategy. Appendices include refresher materials useful in conducting and managing a training event, forms useful in participant recruitment and selection, master copies of transparencies and handouts, and an instrument for evaluating the training experience. See also 81-0918.

81-0918
Management Skills for Alcohol Program Administrators: Participant Workbook.
National Center for Alcohol Education, Arlington, Va.
Rockville, Md., National Institute on Alcohol Abuse and Alcoholism (DHEW, ADAMHA) (DHEW Publication No. (ADM)78-720), 180 p., 1978.
Available from: GPO; Stock No. 017-024-00818-4.

A workbook for use in conjunction with "You, Youth, and Prevention: Trainer Manual" is designed to meet the needs of alcoholism service workers and health educators. The workbook contains the handouts participants need for the sessions outlined in the manual. See also 81-0917.

RESEARCH AND EVALUATION

81-0919
What Do Teens Know About the Facts of Life?
Amonker, R. G.
Journal of School Health 50(9):527-533, November 1980.

An exploratory study of 372 teenagers passing through the Planned Parenthood Office of Southwest Missouri in Springfield over a 12-month period investigated the extent of the adolescents' sexual knowledge. Eighty-two percent of the respondents were from grade 10 or above. Sixty-seven percent claimed to be experienced sexually; however, only 37 percent stated that they had used some method of birth control at some time. When asked to rank their sources of sexual information in order of importance, the respondents ranked friends first, mass media second, and parents third. In the area of knowledge, the questionnaire results indicated that subjects lacked knowledge concerning birth control practices, drugs, and devices, but that they were generally well informed concerning venereal disease. Young women scored better than young men on all sections of the questionnaire, and those who had remained in school scored better than those who had not. These results suggest that formal sex education programs, which are currently part of required school curricula in six States and the District of Columbia, should be mandated in all States. 13 references.

81-0920
Mass Media, Alcohol and Drugs: A New Trend.
Breed, W. and De Foe, J. R.
Journal of Drug Education 10(2):135-143, 1980.

While alcohol and other drugs have similar physiological effects, they are defined differently by society; that is, alcohol is generally approved and other drugs are generally disapproved. The mass media has tended to reflect these views. However, a shift has been noted. Several televised situation comedies have presented marijuana as a relatively harmless escape from the cares or boredom of life. Most specialists studying the effects of the media believe that it does influence individual attitudes and

behavior. Unfortunately, the two antidrug media devices, namely, public service announcements and news releases, have proven ineffective. The few television dramas that cast drug use in a negative light seem to have some positive effects. Television programming is most inimical when it includes incidental treatments of drug or alcohol use that render such use in a humorous light. Continuation of this trend may encourage a permissive attitude toward marijuana and other drugs. 11 references.

81-0921
Alcohol: A Description and Comparison of Recent Scientific vs. Public Knowledge.
Buckalew, L. W.
Journal of Clinical Psychology 35(2):459-463, April 1979.

A review of the literature on alcohol use and abuse since the "rediscovery" of the fetal alcohol syndrome (FAS), and a survey of female students allowed comparison of recent scientific advances with the knowledge of the general public. The research concentrated on a search for explanations of alcohol use and abuse and on several areas of biological morphogenesis. Significant documentation exists for FAS that validates both physiological and developmental attributes. As an index of public knowledge, a 23-item true-false alcohol questionnaire was administered to 69 high school, 67 college, and 52 graduate students; the survey represented statements relative to the nature, etiology, effects, variables, and consequences of alcohol use and abuse. The composite mean score was less than 60 percent correct, suggesting significant misinformation and misconceptions about alcohol. The study indicated that education has a positive though minimal effect on alcohol knowledge, that females were generally more knowledgeable than males, and that whites were more knowledgeable than blacks. Clearly, a major problem exists in transfering alcohol knowledge from the scientific community to the general public. 27 references.

81-0922
Use of Over-the-Counter and Home Remedies by College Students.
Cafferata, G. L.; Lach, P. A.; and Reifler, C. B.
Journal of the American College Health Association 29(2):61-65, October 1980.

Two surveys, one involving a random sample of 302 students at the University of Rochester in New York and the other involving all professional staff responsible for their care, were designed to develop base-line data on self-medication and indicators of need for health education programs. The student questionnaire asked for (1) names of brands of nonprescription drugs used for 27 symptoms and (2) factors influencing the selection of over-the-counter (OTC) drugs. All medications used by consumers for 17 of the 27 symptoms were evaluated by university health service staff. The pattern of student use of OTC drugs reflected patterns observed in other populations. Analgesics and cough and cold remedies were the most widely used internally administered drugs, while toothpaste, antimicrobial skin ointment, and acne aids were the most widely used topical products. Adoption of particular OTC products was reportedly influenced more by friends, packaging, and media promotions than by health professionals such as doctors, nurses, or pharmacists. Nervous tension, insomnia, minor burns, cold scores, and constipation were the most inappropriately treated symptoms. The results of this study suggest the need in this clinical population for health education programs in stress and anxiety management, skin care, and gastrointestinal problems. They also suggest the need for health professionals to ask their patients about OTC drug use on a routine basis. 12 references.

81-0923
Guide to Health Needs Assessment: A Critique of Available Sources of Health and Health Care Information.
Chambers, L. W.; Woodward, C. A.; and Dok, C.
Ottawa, Ontario. Canadian Public Health Association, 26 p., 1980.

A critique of the available sources of health and health care information is offered for use by regional health planning authorities, public health units, and instructors in health evaluation and research planning courses for professionals. Topics include definitions of different approaches to health needs assessment, advantages and disadvantages of various sources of health and health care information, and examples of the use of different information sources in health needs assessment. Pre- and posttests for users are included.

81-0924
Forging an Identify for the Non-Smoker: The Use of Myth in Health Promotion.
Chapman, S. and Egger, G.
International Journal of Health Education (Geneva) 23(3, Suppl):16 p., July-September 1980.

Five examples of cigarette advertisements in the Australian print media are analyzed to determine the role of myth in promoting smoking and to study the possibility of adapting the mythical process to promote nonsmoking.

Cigarette advertisements are decoded through the identification of signifiers, referent systems, problems, promises, myths, binary opposites, and exhaustive common denominators. Developing an advertisement requires the creation of a problem around which the advertisement will offer a promise energized by a myth. The problem may be about negative qualities or associations related to the product or to the users or potential users. Myth acts as an anxiety reducing mechanism by restating the basic dilemmas of the human condition. The process of reducing surface presentations to binary opposite substructures is achieved through the structuralist-analytical process called the exhaustive common denominator. Referent systems are the social settings that contain the desirable values or moods, while signifiers are the elements that generate these referent systems. An adaptation of the mythical process to the development of a positive mythical status for nonsmokers is discussed. 25 references.

81-0925
The Nutritional Knowledge and Practices of the Rural Homemakers in a Post and a Non ANP Block.
Devadas, R. P.; Jayapoorani, N.; and Gowri, T. S.
Indian Journal of Nutrition and Dietetics 14(7):157-160, 1977.

A study involving 30 villages in the Coimbatore district of India was designed to assess the nutritional knowledge and practices of selected rural homemakers who had participated in the Applied Nutrition Programme (ANP) compared with those who had not participated. Ten randomly selected villagers from each of the 30 villages (15 of which had participated in the ANP and 15 of which had not participated), were selected as the sample population. Data were collected during 20-30-minute interviews. Interview results confirm that the three components of the ANP, namely, production of protective foods, consumption of protective foods, and education concerning nutrition, had improved the nutritional knowledge and practices of the rural homemakers. Results indicate that nutrition education should become an integral component of all community development and educational activities. 3 references.

81-0926
Patient Comprehension Profiles: Recent Findings and Strategies.
Doak, L. G. and Doak, C. C.
Patient Counselling and Health Education 2(3):101-106, 1980.

Measurements were made of the reading levels of (1) 100 booklets, pamphlets, and special instructions in use at the Public Health Service Hospital in Norfolk, Virginia, and (2) 87 representative patients. The reading levels of the literature was evaluated using the SMOG readability formula; one experienced rater conducted the readability assessment. A profile of the reading levels demonstrated that the written materials ranged from the 4th to the 16th grade reading level, but that few materials fell below the 8th grade level. Two brochures--a word recognition test and two cloze tests, one at the 10th grade level and one at the 5th grade level--were used to assess the reading levels of the subject patients. Word recognition scores of the patients showed that more than 60 percent had word recognition levels at the 7th and 8th grade levels, and that the average word recognition skill level was four or five grades lower than the average patient's claimed educational level. Comprehension profiles derived from the tests indicated that 36 percent of the patients could not read well enough to take the fifth grade cloze test, that 20 percent of the patients could not understand either written or spoken instructions, and that 49 percent of the patients comprehended at the fifth grade level. These results suggest that health instruction materials should present only the minimum essential information in simple language and sequential order, with an emphasis on the patient's point of view and behavior rather than theory. 9 references.

81-0927
Helping Families Face the Crisis of Cancer.
Giacquinta, B.
American Journal of Nursing 77(10):1585-1588, October 1977.

A model of the family's reaction to and acceptance of cancer in a family member is described. During the first of four stages, immediately following the initial diagnosis of cancer, the family proceeds from feelings of shock and strain through periods of functional disruption, searches for the meaning of the disease, and attempts to share the revelation with others, to a period in which strong emotions are confronted. During the second stage, the patient ceases to perform familiar roles and the family undergoes a reorganization and begins to frame memories of the affected person's life. The bereavement or third stage, which coincides with the death or imminent death of the patient, is characterized by an experience of separation and loss followed by mourning. Once mourning is completed, the family moves into the fourth stage by reestablishing its ties with the broader social network. Therapists dealing with families affected by cancer should be aware of these stages. 5 references.

81-0928
The Adolescent Alcohol Questionnaire: Its Development and Psychometric Evaluation.
Gliksman, L.; Smythe, P. C.; Gorman, J.; and Rush, B.
Journal of Drug Education 10(3):209-227, 1980.

Twenty-four seventh graders, 81 eighth graders, 38 ninth graders, and 60 tenth graders from 4 schools in Ontario, Canada, were administered a preliminary version of a questionnaire designed to measure attitude, motivation, behavior, and knowledge associated with alcohol use and abuse. Attitudes were measured via a Likert formula and a semantic differential format. Behavioral indices included the Adolescent Alcohol Involvement Scale, a 14-item multiple choice test that has been used as an index of alcohol abuse, and a table that allowed students to indicate the amount of alcohol they consumed. Motivational measures distinguished between drinking used as an escape (personal effects) or as a festive activity (social effects). The questionnaire also included a 20-statement knowledge segment formulated to reflect the information presented in the students' alcohol curricula. The resulting Adolescent Alcohol Questionnaire, with its multiple attitude measures and general measures of motivation and behavior, would probably be useful in the evaluation of other education programs. 34 references.

81-0929
College Student Interests in Drug Education Go Further Than Illicit Drugs.
Gold, R. S.; Duncan, D. F.; and Sutherland, M. S.
Journal of Drug Education 10(1):79-88, 1980.

A survey of 86 undergraduate students enrolled at the State University of New York at Brockport gathered information on their drug information interests. The survey allowed students to write out questions they thought college students were interested in concerning herbal drugs, over-the-counter drugs, prescription drugs, unrecognized drugs, tobacco, alcohol, and illicit drugs. Each of the seven categories of drugs was precisely defined on the questionnaire. The 51 female and 35 male respondents wrote 541 questions, of which 108 concerned herbal drugs; 103, illicit drugs; 55, alcohol; and 59, prescription drugs. The drugs whose effects were of greatest interest were the herbal drugs, followed respectively by illicit drugs, over-the-counter drugs, unrecognized drugs, alcohol, tobacco, and prescription drugs. There were 188 questions about the effects of drugs, and 82 questions about the hazards associated with drugs. Application of the Pearson Product Moment Correlation Coefficient to measure associations among the questions indicated a total lack of negative correlations. Findings reveal that the typical college-level drug course does not correspond with student interests, suggesting that a survey of student interests should precede the planning of such courses. 12 references.

81-0930
Drug Education--A Turn On or a Turn Off?
Goodstadt, M. S.
Journal of Drug Education 10(2):89-99, 1980.

A review of all 15 available studies reporting negative effects of drug education programs demonstrates that these programs exhibit both negative attitudinal and behavioral effects, usually in combination with positive program effects. Most studies of the impact of drug education have been hindered by inadequate measurement techniques. Major flaws include use of survey techniques that provide observations at only one point in time, inattention to the types and validity of questions asked of subjects, inconsistency in findings that indicate that drug education results in increased levels of drug use, reliance on correlational rather than causal data, neglect of alternative hypotheses to explain increased drug use among those exposed to educational programs, and flawed data resulting from selective attention by observers. A review of the experimental evidence indicates that (1) relatively few scientifically conducted studies have demonstrated a negative impact by drug education programs; (2) the majority of reported negative findings have involved a significant increase in reported drug use among subjects; (3) all reported negative findings have been associated with the reporting of positive findings in the same study; and (4) no common program characteristic was detectable in the programs with negative results. Evidence also suggests that apparent increases in drug use may actually be increases in reported drug use. 30 references.

81-0931
Improved Detection of Human Breast Lesions Following Experimental Training.
Hall, D. C.; Adams, C. K.; Stein, G. H.; Stephenson, H. S.; Goldstein, M. K.; and Pennypacker, H. S.
Cancer 46(2):408-414, July 15, 1980.

A study involving 20 female volunteers serving as trainees and 6 females with breast lesions serving as stimulus subjects was designed to evaluate the effectiveness of breast examination training using silicone models. Ten trainees received a 20-30-minute training session with the silicone model, while the remaining 10 trainees performed an unrelated activity. The stimulus subjects, who had a total of 13 benign breast lumps, were examined by both groups of trainees before and after either the training session or

the period of unrelated activity. The dependent measures from the pre- and posttests were duration of each breast examination, number and location of each reported detection, and confidence rating of each detection or false positive detection on a scale of 1 to 5. Results indicated that following the training the percentage of correct detections, duration of examination, and reports of false positive increased. Confidence in correct detections and false positive detections also increased. These results suggest that the training was highly effective and that there exists a need for a more complex breast model for training discrimination between normal nodularity and breast lesions. 19 references.

81-0932
The Cloze Procedure.
Holcomb, C. A. and Ellis, J. K.
Health Education 9(6):8-10, November-December 1978.

A study of 84 elderly adults who eat a noon meal at the 13 program sites operated by the Oregon District Four Elderly Nutrition Program was designed to determine the readability of selected patient education materials using a comprehension-measuring device called the cloze procedure. The instruments used in the investigation were three separate cloze test forms, each of which used printed information on hypertension. The Dale-Chall readability formula was used to revise the readability level to conform to a sixth grade reading level, and the Coleman readability formula was used to predict the cloze score for the printed material. Results indicated that the subjects scored significantly lower than had been predicted by the Colman formula. The study verified the observation by other researchers that the cloze procedure is more effective than the Colman and Date-Chall procedures in contrasting the relative difficulty of the content of different samples of printed material. The cloze procedure also seems to be able to assess the patient's recognition of words and sentence structure. Implications for health educators in formulating educational prescriptions for their patients are discussed. 10 references.

81-0933
Applications of a Theory of Drug Use to Prevention Programs.
Huba, G. J.; Wingard, J. A.; and Bentler, P. M.
Journal of Drug Education 10(1):25-38, 1980.

An interactive theory of drug use can provide the framework for integrating current knowledge and initiating new research in prevention programs. The major characteristics of the theory include comprehensiveness, a design for empirical testing using causal models, a differentiation of direct and indirect causes of drug use and its consequences, and a delineation of mechanisms associated with different stages of drug use. The theory views initiation of drug use as due to self-perceived behavioral pressure arising from the user's intimate support system; continued drug use as due to the reinforcing effects of drugs; cessation of drug use as due to different processes for different individuals; and relapse into drug use as due to peer pressure, organismic cravings for drugs, personality, and environmental stresses. The model suggests that primary prevention programs must address themselves simultaneously to aspects of the individual's intimate support system, personality, and the way the individual combines information into a judgement of perceived behavioral pressure. In the design of treatment, programmers must consider different ways in which individual patterns of drug use are maintained through reinforcement, affective benefits, the avoidance of withdrawal, and personality change. Thus, professionals will need training in a multitude of disciplines, and future evaluation designs will have to be more comprehensive than they are now. 14 references.

81-0934
Counselling Needs of Women With a Maternal History of Breast Cancer.
Kelly, P. T.
Patient Counselling and Health Education 2(3):118-124, 1980.

Thirty-nine women whose mothers had had breast cancer were interviewed to determine their own needs, concerns, and health practices pertaining to breast cancer. The subjects were obtained from a group of women who had participated in a previous breast cancer epidemiology project at the University of California at San Francisco. Each participant was interviewed for 1 hour in a semistructured interview schedule. The grounded theory method was used to analyze the data collected via the nonstructured items. Data analysis revealed that (1) many of the women had feelings of guilt and anxiety after the diagnosis of their mother's breast cancer; (2) 79 percent practiced breast self-examination (BSE); (3) both BSE practitioners and nonpractitioners thought that their emotional reactions to cancer might keep them from performing an adequate examination; (4) subjects sought frequent breast examinations by professionals; (5) professional examination relieved anxiety in the subjects; and (6) 82 percent felt that the risk of breast cancer was increased due to their maternal history of breast cancer. Though the subjects were also concerned about the effects of birth control pills, radiation, and other factors influencing breast can-

cer, they had only vague, and sometimes incorrect, information about the magnitude of risk. Results indicate that women with maternal histories of breast cancer should receive continuing counseling and information services. 19 references.

81-0935
Impact of Providing Milk Options and Nutrient Information in School Lunch Programs.
Martilotta, M. and Guthrie, H. A.
Journal of the American Dietetic Association 77(4):439-443, October 1980.

A study of 1,400 junior and senior high school students in rural Pennsylvania was designed to assess (1) the impact on consumption and waste of offering students a choice of whole, skim, and low-fat milk, and (2) the effect of providing nutrition information and the factors that influence student choices in this area. A 10-day base-line assessment period, during which no milk choice was offered, was followed by a 14-day period, during which a choice was offered. The final phase involved availability of the milk choice along with provision of nutrition education. Assessments were made of the number of students buying milk, the type of milk chosen, the number of milk cartons purchased per student, the number of each type of milk carton returned unopened, and other variables that might affect milk consumption. Results indicated that offering a choice of whole, skim and low-fat milk increased student participation in the lunch program to 71 percent compared with 65 percent during the base-line period. Although no change in student participation followed the introduction of nutritional information, there was a significant increase in the percentage of both junior and senior high school students choosing low-fat milk. However, introducing a choice of milk and providing nutritional information were both associated with a decline in overall milk consumption. Results are detailed by experimental period, type of student, and milk choice. 21 references.

81-0936
Methodological Considerations to Improve Anti-Smoking Research.
O'Rourke, T. W.
Journal of Drug Education 10(2):159-171, 1980.

An overview of recent research in smoking behavior reveals significant methodological limitations that detract from the usefulness of such research: (1) behavioral groups (regular smokers, occasional smokers, etc.) are defined differently by different researchers, making comparisons between studies difficult; (2) the unacceptable nature of smoking, particularly the well-known negative feelings of adults toward teenage smoking, often result in dishonest reports by subjects; (3) the univariate form of analysis employed by most studies fails to address the interaction of psychosocial variables that may serve to influence the development of youth smoking behavior; (4) most measurement instruments used by researchers do not pass beyond content or face validity, which is limited to subjective analysis; and (5) researchers concentrate on cessation or modification of smoking behavior, neglecting prevention efforts. To ameliorate these weaknesses, future researchers should develop a standard glossary with operational definitions of each major term, concentrate on means of pinpointing and counteracting the dishonesty of study subjects, use multivariate analysis, emphasize instrumentation that has reliability and concurrent or predictive validity, emphasize preventive programming, and incorporate outcomes other than cessation as criteria of program success. 37 references.

81-0937
Expected and Actual Knowledge of Hospital Patients.
Pool, J. J.
Patient Counselling and Health Education 2(3):111-117, 1980.

A survey of six general hospitals in the Netherlands studied the relationship between doctors' and nurses' perceptions of patient's knowledge and (1) patients' reported informative behavior and (2) the actual level of patients' knowledge. Forty-eight doctors and four hundred and forty-two nurses filled out a questionnaire reporting percentages of patients they would expect to have valid knowledge in each of a number of fields. The same items were presented to 754 inpatients in the form of questions. About 50 percent of the patients had adequate medical knowledge and knowledge of the hospital environment; the actual knowledge levels of patients agreed with the expectation of doctors and nurses; and professional expectations were lowest concerning patents' knowledge of their own conditions. Analysis of data on the ward level revealed that, particularly in the case of knowledge of the hospital and ward, the professionals' expectations exceeded the actual knowledge; in the medical category, this applied only to knowledge of anatomy and physiology. Knowledge expectations of doctors were positively related to a more professional attitude; among nurses, a more bureaucratic attitude, greater job satisfaction, and less uncertainty about occupational roles correlated with lower expectations. 7 references.

81-0938
Psychoactive Medicinal and Nonmedicinal Drug Use Among High School Students.
Roush, G. C.; Thompson, W. D.; and Berberian, R. M.
Pediatrics 66(5):709-715, November 1980.

In a random sample of 1,094 New Haven, Connecticut, area high school students, nonmedicinal drug use was 1.9 to 11 times greater among those students with a history of 3 or more recommendations of a psychoactive drug by a physician as compared to those students who had never received such a recommendation. The cross-sectional study was based on a supervised, self-administered questionnaire distributed by survey teams at 20 high schools during the 1972-1973 academic year. The relationship between medicinal psychoactive drugs and nonmedicinal drug use persisted when potentially confounding variables were controlled, and was statistically significant for cigarettes, marijuana, amphetamines, barbiturates, and heroin use. The relationships of cigarette, marijuana, amphetamine, and heroin use to physician recommendation of a psychoactive drug appeared to be as strong as those of previously identified correlates of nonmedicinal drug use. Although causal mechanisms cannot be inferred from these data, the results may have implications for preventive programs aimed at decreasing nonmedicinal drug use. 30 references.

81-0939
Sources of Information About "Drugs."
Sheppard, M. A.
Journal of Drug Education 10(3):257-262, 1980.

Sixteen studies of how people get information about drugs were examined to determine the best methods for reaching target audiences. The studies were categorized by the kinds of questions asked and by date, sample, and results. Professional adults reported that they would first turn to other professionals for information, then to the mass media. Students indicated parents, television, and friends, respectively. Drug users said that they would ask friends, nonusers, or physicians for information. Other findings indicated that youthful users thought that other users or ex-users were the most credible sources, that youthful nonusers found scientists and the media the most credible, that adult users perceived professionals as the most credible, that students asked older siblings for advice, and that most students had never sought help. These findings and others reveal the need for (1) long-term studies in this area, (2) an examination of the effectiveness of the sources chosen by specific target audiences, (3) careful tailoring of media messages to responsive target audiences, and (4) educational programs that will better inform the sources. 16 references.

81-0940
What Do Young Adults Really Know, Think and Do About Health?
Slayen, P. W.
South African Medical Journal (Cape Town) 57(21):877-880, May 24, 1980.

A survey of 665 first-year students at a South African university was conducted to determine students' health knowledge, sources of knowledge, and health beliefs and attitudes. Findings reveal that (1) few students thought their health instruction in primary and secondary schools had been adequate; (2) students obtained most health knowledge from books, friends, and the mass media; (3) students were aware of the detrimental effects of smoking and alcohol on health; (4) 78 percent thought that parents should discuss sex openly with their children; (5) 20 percent of the students indicated that they seldom participated in sports, and 11 percent that they never participated; (6) 17 percent were regular smokers and 13 percent were regular drinkers; (7) 37 percent had experienced sexual intercourse; and (8) students were able to distinguish between fact and fallacy about common medical myths and treatments even though many were ignorant of the relationship between health behavior and long-range consequences. Findings suggest that health education in South Africa should occur in the formative years and should receive the same emphasis as other academic subjects.

81-0941
Alcohol Portrayal in the Mass Media.
Small, J.
Alcohol Health and Research World 5(1):30-34, Fall 1980.

Recent research on modeling theory indicates that constant exposure to television programs extolling the virtues or dangers of alcohol consumption can influence drinking habits. Approximately 98 percent of all households in the United States own at least one television, and the average household viewed an estimated 6 hours and 28 minutes a day during the 1978-79 television season. An analysis of 80 prime-time hours in March 1973 and 21 hours in November 1973 revealed that incidents involving alcohol consumption were depicted at a rate of 1.3 to 1.6 per hour. Another study found alcohol consumption depicted in 201 of 249 programs viewed over 250 hours during a 2-month period. Other studies support these findings and suggest that television and other media fail to depict consistently the effects of alcohol use and abuse. Researchers agree that television's portrayal of alcohol use seems to "normalize" drinking. In response to these findings, a project funded by the National Institute on Alcohol Abuse

and Alcoholism promotes cooperation between project staff and television writers, producers, and directors. Such cooperation should result in the inclusion of "reality reminders," which would be added to scenes and show the negative side of alcohol use. 14 references.

81-0942
Comprehensive and Continuing Care; Proceedings of the Fourteenth Annual Meeting on Prospective Medicine and Health Hazard Appraisal, St. Petersburg, Florida, October 5-8, 1978.
Society of Prospective Medicine, Indianapolis, Ind.
Bethesda, Md., Health and Education Resources, 95 p., February 1979.

Topics of the 14th Annual Meeting of the Society of Prospective Medicine include an overview of health hazard appraisal (HHA); the national perspective on health education; the prevention value of the annual physical examination; a cost-effective lifestyle improvement program; application of a risk-factor identification and reduction program in a corporate setting; prospective medicine's dependence on scientific methodology; the Greendale Project; comprehensive medicine; the relationship between physical fitness test scores and HHA indices; the effect of eliminating self-assessment of frame in HHA; the Hite Project; risk appraisal for the low risk person; comparative mortality; a method for improving risk factor appraisal; prospective health and wellness; the role of prospective medicine in medical education; the family physician; changing lifestyles through changing organizational cultures; and statistical evaluation of an inpatient multiple risk factor modification program.

81-0943
Evaluation of Simulations and Games: A Comprehensive Procedure and a Case History.
Thiagarajan, S.
Health Education Monographs 5(Suppl. 1):64-73, 1977.

A procedural model for evaluating simulations and games used in health education programs is illustrated by a case history of the evolution of a game through repeated evaluations. The four major dimensions in evaluating a game are the purposes of evaluation, sources of evaluative data, emphasis on main or side effects, and timing of evaluation. Sequential stages in a typical evaluation are evaluation of the prototype game by the designer, appraisal by experts, pilot demonstrations with a group of locally available players, tests in a typical setting, tests in the field via controlled study run by an outside evaluator, and long-term evaluation by consumer groups. Depending on the length and complexity of the game, this chronology of evaluation, not including the final long-term evaluation, may last from 2 months to 2 years. Each stage is either formative or summative or both. ("Summative," in this case, indicates that the evaluator is attempting to prove the game's effectiveness, and "formative" indicates that the evaluator is attempting to improve the game's effectiveness.)

81-0944
Assessing Effects of Mass Media Campaigns: An Alternative Perspective.
Wallack, L. M.
Alcohol Health and Research World 5(1):17-29, Fall 1980.

A framework for assessing the effects of mass media alcohol awareness campaigns is discussed. Programs promoting moderate use of or abstinence from alcohol, tobacco, or drugs implicitly rely on the theory that attitude change precedes and predicts behavior change. However, research on attitudes and behavior suggests that the relations that do exist between the two are not clear. Furthermore, several reviewers have found that the effects of mass media campaigns designed to alter alcohol-related behavior are negligible, though combinations of mass media and interpersonal or community organization approaches have proven effective. In evaluation, studies assessing the effects of mass media campaigns appear to have a limited impact on the design and expectations of other campaigns. Methodological problems flaw the evaluations of most media efforts. These findings suggest that campaigns should be evaluated by measuring behavior change. Group-level analysis can augment cross-sectional designs by means of surveys, examinations of institutional records, interviews with those who interact with members of the target audience, and direct observation of the subjects. Other sources of evaluative information include social and health indicators, official statistics, and ethnographic studies. Numerous references.

81-0945
Childbirth Education Evaluation: The Indianapolis Experience.
Zwirn, E. E.; Fry, L. R.; Reed, D. B.; and Martin, R. E.
Birth and the Family Journal 6(2):105-108, Summer 1979.

Data collection activities conducted by the Indianapolis-based Maternity Family League of Indiana during 1977 are examined to (1) provide a framework for understanding the initiation and implementation of an agency-wide data collection effort, and (2) demonstrate ways in which data

collection is essential for agency goal and priority setting. Four sets of data were examined: the registrar's log, which demonstrated the increasing number of parents prepared for childbirth; the dirctor's files, which indicated the number of childbirth education (CBE) instructors and assistants; family registration cards; and a form completed by parents after childbirth, which provided data concerning the labor and birth experience and the couples' evaluation of CBE classes and instructors. Data was organized to facilitate keypunching and mechanical processing by computer. Findings based on data processing are discussed in terms of client origin, source of referrals, maternal characteristics, the labor and delivery experience, instructor and class evaluation, and infant-feeding preference.

RISK REDUCTION

81-0946
Promoting Health and Fitness--A New Role for Hospitals.
Carpenter, D. C., Jr.
Hospital and Health Services Administration 25(3):16-30, Summer 1980.

Government support of physical fitness, exemplified by a bill passed by the Senate Subcommittee on Health and Scientific Research that would provide $12 million for model projects in physical fitness, should encourage hospitals to become involved in such programs. Fitness and exercise programs have also been supported by health service associations, various government agencies, the Blue Cross-Blue Shield Company, numerous industries, the American Hospital Association, and the wellness movement. Hospital professionals particularly suited to fitness programming include dietitians and nutritionists, physical therapists and exercise physiologists, cardiac rehabilitation specialists, clinical lab technicians, and social workers. An emerging concept in the physical fitness movement is the hospital physical fitness center with three operational divisions, fitness counseling services, fitness facilities, and fitness research activities. Though there are several unresolved issues associated with the hospital's role in physical fitness, the potential for containing medical costs through physical fitness programming remains unchallenged. 22 references.

81-0947
Young People and Smoking: The Need for Broader Concepts.
Dekker, E.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 229-234, 1980.

A review of the factors that influence smoking by young people and of the effects of health education on smoking behavior reveals a need for broader concepts within and outside the health education field. Factors associated with smoking by teenagers include parents and siblings who smoke, parents with low socioeconomic status, single-parent households, urban environments, low academic achievement, and individual rebelliousness and anticipation of adulthood. It is difficult to determine whether antismoking programs aimed at youth have been successful; at present (1) most programs are never evaluated, (2) there are too many "one-shot" programs, and (3) little attention is paid to the different motivations of nonsmokers and new and dependent smokers. Future programs should be initiated with a precise description of the target group, varied in the use of media, based on the cultural values of the target group, planned as long-term ventures, addressed to the needs of the individual as a peer group member, and integrated into a larger social movement. 17 references.

81-0948
Beliefs of Teenagers About Smoking and Health.
Green, D. E.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 223-228, 1980.

An examination of the prevalence of smoking among teenagers and the characteristics of the teenage smoker reveals influences leading adolescents to smoke and possible means of discouraging smoking in this age group. One in six adolescents 12-18 years old are cigarette smokers. Although the rate has remained constant among young males for the past 10 years, the percentage of young females who smoke has steadily increased. Demographically, smokers seem to differ from nonsmokers because they tend to have parents who smoke, to come from single-parent families or families without parents, have parents who did not attend college, have little desire to go to college, work outside the home, have friends who smoke, and use alcohol or controlled substances. In the area of perceptions and attitudes, smokers are more likely than nonsmokers to (1) discount the seriousness of smoking, (2) believe that smokers are more at ease with other

persons, (3) believe that experimenting with smoking is not dangerous, and (4) believe that teenagers should have adult rights and responsibilities. These findings suggest that an effective antismoking program should consider parental and peer pressure influences. 6 references.

81-0949
Constructive Peer Relationships, Social Development, and Cooperative Learning Experiences: Implications for the Prevention of Drug Abuse.
Johnson, D. W.
Journal of Drug Education 10(1):7-24, 1980.

One approach used to prevent drug abuse is to provide socializing experiences that help children and adolescents acquire basic social competencies. These competencies are developed within meaningful interdependent relationships. While adult-child relationships have long been emphasized, there is increasing evidence that constructive peer relationships are necessary for successful socialization. Since the children and adolescents most in need of constructive socializing experiences tend to come from stressful, abusive, or indifferent families, the most promising approach to intervention is within the school. Instructional experiences may be structured cooperatively, helping students achieve good relationships with their peers and allowing teachers to emphasize (1) the development of social skills, roles, and sensitivity; (2) peer accountability for developing values and self-control; and (3) resistance of social pressures to abuse drugs. 30 references.

81-0950
The National Consumer Communications Program.
Kime, T. Q.
Journal of the American Optometric Association 51(4):350-352, April 1980.

During the first 15 months of the American Optometric Association's National Consumer Communication Program (NCCP), 111 million net impressions were made on Americans who either read or viewed program messages. By December 1979, the NCCP had reached 88 percent of its primary target audience (female homemakers 25-54 years old), with an average of seven impressions for each audience member. The NCCP presented forty-two 30-second messages on prime-time or daytime television, printed 32 insertions in 12 highly read consumer magazines, and disseminated 13 million copies of a family guide to vision care. Goals for 1980 included increased awareness of the importance of periodic professional vision care, promotion of the family doctor of optometry, and provision of information about the differences between professional optometrists and others in the vision care field. The target population was expanded to include middle-aged and geriatric populations. Promotional plans included use of print ads, television specials, and membership awareness and involvement programs.

81-0951
The Belgian Heart Disease Prevention Project: Changes in Smoking Habits After Two Years of Intervention.
Kornitzer, M.; Dramaix, M.; Kittel, F.; and De Backer, G.
Preventive Medicine 9(4):496-503, July 1980.

Changes in smoking habits were investigated among 19,390 40-59 year old men participating in the Belgian Heart Disease Prevention Project, a controlled multifactorial prevention trial in which 30 Belgian industries were paired and randomized into a control or intervention unit. In each intervention factory, subjects from the two highest deciles of a coronary risk curve were given semiannual individual advice, while a health education campaign was initiated with all others. After 2 years, high risk subjects and random samples from the control and intervention groups were compared regarding smoking behavior. Among high risk subjects in the intervention group, 18.7 percent stopped smoking, as compared to 12.2 percent in the control group; low risk intervention participants scored the same as the control group. Three base-line factors discriminated significantly between smokers and former smokers of the high risk intervention group at 2 years: former smokers had smoked less at program entry, had made more frequent attempts to stop smoking, and lived in a different region of the country. For the control group, two base-line factors discriminated between former smokers and smokers at 2 years: former smokers had a higher education level and had tried more frequently to stop smoking. Findings are compared with results of other smoking cessation programs. 23 references.

81-0952
Primary Prevention of Heart Attacks: The Multiple Risk Factor Intervention Trial.
Kuller, L.; Neaton, J.; Caggiula, A.; and Falvo-Gerard, L.
American Journal of Epidemiology 112(2):185-199, 1980.

The Multiple Risk Factor Intervention Trial is a collaborative clinical trial, involving 22 clinical centers, a coordinating center, and an electrocardiographic (EKG) and laboratory center, that is designed to determine whether the reduction of serum cholesterol by dietary intervention, reduction in cigarette smoking, and treatment of hyperten-

sion by drugs or diet results in a reduction in mortality due to heart disease. The 6-year study involves 12,866 men, 35-57 years old, who were considered as high risk but who were free of coronary heart disease prior to entry into the study. The subjects were randomized into a first group that received active intervention, including nutrition counseling, modification of smoking behavior, and treatment of high blood pressure by diet or drugs, and a second group of equal size that was referred to personal physicians for normal treatment of risk factors. Three separate examinations or screening visits were made to the participants prior to randomization to determine each subject's level of risk. Measurements of outcome in the study include deaths due to arteriosclerotic heart disease, total mortality, and nonfatal myocardial infarction. All participants are contacted at least every 4 months. Results of the followup thus far have indicated that treatment of hypertension and reduction of cigarette smoking have been accomplished according to design, that blood cholesterol has not been reduced as much as required, and that the final outcome of the study will greatly influence ongoing and planned public health programs. 16 references.

81-0953

Genetic Counseling in Sickle Cell Anemia and Related Hemoglobinopathies.

Murray, R. F., Jr.

Urban Health 9(9):35-37, 46, November 1980.

Genetic counseling for persons affected by sickle cell anemia or related hemoglobinopathies has assumed increased significance due to (1) the ability to detect many hereditary illnesses through simple biochemical tasks and (2) the increased public awareness of preventive medicine. The genetic counselor is responsible for establishing the risk of disease recurrence, interpreting the risk in meaningful terms, aiding the counselee in formulating a plan of action, and following up the counseling to reinforce the risk figures and estimate its effect on the counselee. Discussing the genetics of the disorder is a small part of the counseling process compared to assessing the emotional makeup and social setting of the couple under consideration. The goals of genetic counseling in sickle cell anemia are to communicate to the counselee a functional understanding of the disease, correct any misconceptions concerning the disease, relieve any anxiety, and discuss alternative reproductive options with at-risk couples. Counselors should be aware of the counselee's educational background, emotional needs, and attitudes. 3 references.

81-0954

Final Report: Can-Dial Telephone Cancer Public Information System.

New York State Dept. of Health, Buffalo. Roswell Park Memorial Inst.

Buffalo, N.Y., the Institute, various pagings, July 31, 1977.

The Can-Dial telephone cancer public information system is evaluated. Initiated in 1973, the system provides callers with 51 tape-recorded messages on cancer, and is operational 16 hours a day, 7 days a week. The evaluation includes a general description of the system, an outline of the methods of evaluation, an assessment of the response to Can-Dial, a comparison of callers and noncaller control subjects, a comparison of callers with and without health problems, comparisons of callers and control subjects with possible cancer problems, an assessment of the impact of the program, and a discussion of program promotion results. Results indicate that twice as many females as males use the service, most callers are motivated to use the service because they wish to quit smoking or because members of their families have had cancer, callers are younger and more educated than noncallers, and callers seem to retain information received. Findings suggest the need to complement the service with mailings to reach high-risk audiences, publicize the availability of the service more extensively, and institute more rigorous followup surveys, including personal interviews with callers, to assess program efficacy.

81-0955

The Health Consequences of Smoking for Women. A Report of the Surgeon General.

Office of the Assistant Secretary for Health (DHHS, PHS), Rockville, Md. Office on Smoking and Health.

Rockville, Md., Office on Smoking and Health, 359 p., 1980

The extent of smoking, the health consequences of smoking, patterns of smoking, and the biomedical, psychosocial, and behavioral aspects of smoking by women is reviewed. Evidence indicates that (1) women are not immune to the damaging effects of smoking; (2) cigarette smoking is a major threat to the outcome of pregnancy and the well-being of the newborn infant; (3) women refrain from smoking, begin smoking, continue smoking, or cease smoking for the same reasons as men; and (4) the reduction of cigarette smoking is the keystone in the nation's long-term strategy to promote a healthy lifestyle. Because great numbers of women did not use cigarettes until the onset of World War II, those women who smoke heaviest are now only in their thirties, forties, and fifties. As these women grow older and continue to smoke, their

burden of smoking-related diseases will grow larger. Cigarette smoking now contributes to 20 percent of the newly diagnosed cases of cancer and 25 percent of all cancer deaths among women. A similar epidemic of chronic obstructive lung disease among women has also begun. Numerous references.

81-0956
Effects of a Controlled-Usage Alcohol Education Program Based on the Health Belief Model.
Portnoy, B.
Journal of Drug Education 10(3):181-195, 1980.

A program incorporating elements of the Health Belief Model (a theoretical construct upon which health-related behavior is predicted) and persuasive communication strategies was designed to determine the effects that a controlled-usage alcohol education program would have on a university population. An attempt was made to increase the college students' levels of perceived susceptibility to alcohol abuse by presenting a profile of the student alcohol abuser and by listing and discussing the psychological, physical, and social problems that occur as a result of alcohol abuse. Study subjects were 286 students enrolled in an exercise and health course at a midwestern university during spring, 1978. The efficacy of the program was monitored via questionnaires administered during the second, fourth, and ninth weeks of the quarter. Results of a multivariate analysis of variance demonstrated that the program as a whole was successful. Univariate comparisons between experimental and control groups demonstrating statistical significance were behavioral intention towards responsible alcohol use and knowledge about alcohol. These and other results suggest that greater emphasis should be placed on the subject's susceptibility to alcohol-related problems. Before the appropriateness of using the Health Belief Model as a theoretical base for a controlled alcohol-use education program can be determined, it will be necessary to use the program on a population with nonresponsible drinking patterns. 39 references.

81-0957
Possibilities for Primary Prevention of Hypertension.
Prineas, R. J.; Gillum, R. F.; and Blackburn, H.
In: Childhood Prevention of Atherosclerosis and Hypertension. Lauer, R. M. and Shekelle, R. B., eds. New York, Raven Press, p. 357-366, 1980.

The major behavioral goals for primary prevention of hypertension in children are reduced sodium intake, reduced caloric intake, and increased caloric output. Studies have indicated that children's sodium intake is often as much as 60 percent above recommended levels. The major source of this excess is raw salt added to foods followed by salt in breads, vegetables, and soups. To reduce the sodium content of the diet to the recommended level, no salt should be added at the table or during cooking and heavily salted commercial foods should be avoided. These goals can be reached by teaching children alternative foods rather than restrictive measures. Cookbooks containing low-salt recipes should be developed, and labeling laws regulating processed foods should be expanded to include information on salt content. A major public education effort utilizing the mass media is necessary to respond to these problems and issues. 30 references.

81-0958
Accentuate the Positive in Drug Education.
Simmons, R. C.
Health Education (Ottawa) 19(2):4-6, October 1980.

By incorporating several basic principles, ensuring that interventions are positive, and avoiding some of the mistakes made by past programs, Canadian drug education programs can succeed at the community, provincial, and national levels. Programs should be founded on sound educational principles, directed by committed staff members who are able to learn from their target audiences as well as teach them, and planned and implemented as interdisciplinary efforts. Typical reasons for program failure include poor integration of interventions, use of scare tactics and moralistic strategies, and use of "drug education" as the ostensible reason for obtaining funding for programs with aims other than drug education. On the community level, drug educators should be aware of linguistic and cultural practices that might hinder or facilitate the educator, of the value of active participation on the part of the target audience, of the importance of using a cross section of community resources, and of the efficacy of programs aimed at highly specific audiences. National programs have been most successful in efforts aimed at enhancing work at the provincial, territorial, and community levels.

81-0959
Health Education--6. Smoking Is Awful.
Thomson, W.
Nursing Times (London) 74(42):1728-1729, October 19, 1978.

To counter the health hazards of smoking (1) doctors and nurses should cooperate with health educators in informing the public of the dangers of smoking; (2) emphasis for

young persons should be on the ' 'dirty'' or socially unacceptable nature of smoking, since warnings of its dangers may encourage its use; (3) doctors, nurses, teachers, and parents must provide good examples; (4) antismoking booklets and posters should be dispersed in places besides doctors' offices or hospitals, such as pubs, bingo halls, betting shops, and cinemas; (5) special facilities for smoking withdrawal and counseling should be established and operated by reformed smokers on a voluntary basis using noninstitutional premises; they should also be free from any form of official health presence; and (6) a realization is needed that smoking is more a social and behavioral problem than a medical one.

81P-0960
Drug Alcohol Team of Oxford Hills (DATOH).
Smith, N. K.
Oxford Hills School District, Superintendent of Schools Office, 2 Pine Street, South Paris, ME 04281
Funding Source: National Highway Traffic Safety Administration, Washington, D.C.
August 1979 - Continuing.

The Drug Alcohol Team of Oxford Hill is designed to build new community attitudes about chemical use and abuse in the Oxford Hills School District of Maine. The program is a component of the Maine Alcohol, Other Drugs and Highway Safety Intervention Project. After four public awareness sessions, committees were developed to address drug and alcohol issues facing schools, medical professionals, law enforcement professionals, and business and industrial interests. Each committee promoted awareness activities and programs within their particular area. Programs that have been developed include public awareness sessions, media campaigns during holidays, business and industry awareness programs, high school assembly programs, inservice educational programs, parent awareness campaigns, and student awareness programs. The program has resulted in a 50 percent reduction in charges of operating a motor vehicle under the influence of alcohol, a reduction in accidents during the Christmas holiday media campaign, a 30 percent increase in alcohol and drug referrals at the Tri-County Mental Health Center, development of procedures and protocols for alcohol and drug-related emergencies at Stephens Memorial Hospital, and an increased effort by law enforcement officials to enforce laws concerning alcohol and other drugs. See also 81P-0832.

81P-0961
Evanston-North Shore Health Department Heart Disease Prevention Program.
Lucia, P. A.
Evanston-North Shore Health Department, 2100 Ridge Avenue, Evanston, IL 60204
1979 - Continuing.

The Evanston-North Shore Health Department Heart Disease Prevention Program is designed to reduce risks associated with cardiovascular diseases. Program services include screening, followup, referral, and health education. The screening component includes assessment of genetic history, current health behavior, blood pressure, height and weight, body fat, cardiovascular recovery response via step testing, blood cholesterol, and diabetes tendencies. Private consultations with health professionals are available. Followup activities include notifying clients concerning screening results, referring clients to medical professionals, and referring clients for health education. The program provides health education workshops in smoking cessation, weight reduction, hypertension management, cholesterol management, stress management, and nutrition for working parents. Workshop techniques include group discussion, problem-solving methods, and lectures. All programs are evaluated via record reviews of program services and followups.

81P-0962
High Blood Pressure Control in Rural Community.
Kotchen, J. M., et al.
University of Kentucky, School of Medicine, Department of Community Medicine, Limestone and Euclid, Lexington, KY 40506
Funding Source: National Heart, Lung, and Blood Inst. (DHHS, NIH), Bethesda, Md.
June 1979 - May 1981.

"High Blood Pressure Control in Rural Community" is designed to develop and evaluate the effectiveness of a high blood pressure control project in rural Kentucky that utilizes existing community resources. High blood pressure control activities include educational efforts directed to the general public, individuals with high blood pressure, and health care providers. Special self-instruction education materials will be developed for use in secondary schools. Using as a model the activities of the Agriculture Cooperative Extension Service, which helps rural families identify and solve problems affecting their welfare, the program will develop and evaluate a program in which extension service paraprofessionals help hypertensive patients and their families adjust to recommended lifestyle changes. Health care provider education will include development of a hypertension syllabus, sponsorship of 1-week university-based miniresidencies in hypertension for physicians, and presentation of a series of hypertension seminars. Evaluation of the overall program will involve general household surveys during the first and fifth

years. The surveys will assess changes in blood pressure and health-related attitudes and behavior in the study community and in a matched control community. Cost and medical effectiveness will also be assessed.

81P-0963
Prevention of Alcohol Problems in Pre-Delinquent Youth.
Wilson, K. M.
Partners, Inc., 1260 West Bayaud, Denver, CO 80223
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.
1978 - Continuing.

Each year the Prevention of Alcohol Problems in Pre-Delinquent Youth program of Denver, Colorado, matches 300-500 10-17 year old adolescents who have alcohol abuse problems with adult volunteers. These volunteers spend 3 hours a week with the youth for at least 12 months. Administered by Partners, a nonprofit organization founded in 1968, the supportive adult relationship combines role modeling behavior with system advocacy in an attempt to return the adolescent to normal functioning. The adults are trained in a minimum of three inservice sessions that address relationship formation; adolescent development; family, school, and community involvement; and alcohol and drug use. Information, communications skills, and coping strategies are presented to the senior partners via role plays, lectures, discussions, and presentations of experiences by former partners. The youth are referred to Partners, Inc., from Denver schools, the juvenile court system, local youth service bureaus, and other agencies. The program is staffed by a full-time, salaried volunteer coordinator, a volunteer health corps coordinator, and several hundred volunteer partners and transportation aides. The process and outcome instruments that allow program assessment include interviews before, during, and after intervention. Multivariate analysis of interview outcomes will be undertaken when full sample sizes are obtained. Preliminary data indicate that program youth have significantly decreased their drinking.

SCHOOL HEALTH EDUCATION

81-0964
Health Instruction: Suggestions for Teachers.
American School Health Association, Kent, Ohio.
Kent, Onio, the Association, 77 p., 1977.

Learning experiences and activities in health education and means of evaluating the efficacy of these experiences and activities are presented for use by health educators. The activities, listed under pertinent health concepts, are designed for use in teaching preschool, early primary school, late primary school, junior high school, or senior high school students.

81-0965
Friends for Life.
Avery, K. T. and Morgan, M. L.
Journal--Oklahoma State Dental Association 70(1):17-19, Summer 1979.

The Oklahoma State Health Department Friends For Life program employs a hygienist and 11 dental educators under the direction of the Chief of Dental Services to teach elementary school children in 19 counties to care for their teeth. Last year, 44,000 children were reached. The course consists of three weekly 1-hour lessons. A toothbrush and dental health materials are provided for each child, and classroom teachers are expected to reinforce the presentations. A study of fourth and fifth grade classes at two representative schools in Creek County was designed to evaluate the efficacy of the program in terms of oral hygiene and gingival health. Pre- and postprogram examinations of each subject consisted of a determination of the amount of debris and calculus present, the Oral Hygiene Index-Simplified, and a measure of gingival inflammation. Results indicated that the two schools exhibited no significant base-line differences, that both groups exhibited improved oral and gingival health, that only the most recent participants showed statistically significant improvements, and that the improvements demonstrated by the most recently exposed school remained significant after 4 months. Results suggest the program should be repeated periodically to reinforce its effectiveness. 8 references.

81-0966
Death Education With Kindergarten-First Grade Groups.
Bowen, G. L.
Journal of Pediatric Psychology 2(2):77-78, 1977.

A death education course designed for young children was offered to a class of 32 kindergarten and first grade students, 5-6 years old, in a rural North Carolina school. The course utilized a text that recounts two children's experiences with the death of a pet bird and, subsequently, with the death of their grandfather. An accompanying adult text familarized the educators with children's per-

ceptions of death. The children were divided into small discussion groups following the reading. It appeared that both kindergarten and first grade students had the same conception of death and that, for the most part, they approached the issue with a minimum of anxiety. Students expressed an awareness of the finality of death, but failed to relate the possibility of dying to themselves. The discussions were characterized by mutual respect for the opinions of others and a sense of group cohesion. 1 reference.

81-0967
The Student Wellness Resource Center: A Holistic Approach to Student Health.
Cohen, M. S.
Health Values: Achieving High Level Wellness 4(5):209-212, September-October 1980.

The Student Wellness Resource Center, established in 1978 at Southern Illinois University at Carbondale, offers the Lifestyling Program, Human Sexuality Services, the Health Activation Program, and the Alcohol Education Project. A paid staff of approximately 20 professionals, graduate assistants, and student workers along with 20 practicum and internship students serves 22,000 students. The programs promote holistic health, self-responsibility, and self-care through a variety of methods designed to affect students in their residential, social, and educational environments. Methods include resident hall raps, classroom presentations, student center programs, special programs, and individual and small group counseling. Other features include a self-care resource room in the health service, an injury prevention program staffed by a part-time physical therapist, and the Wellness Outreach Program situated in the largest residence hall complex on campus. The center was created to allow all students to use health services, to shift the focus of health care to the individual, and to increase the long-term health and well-being of participating students cost effectively. 5 references.

81-0968
How to Cope With Stress in the Classroom.
Davis, C. C.
Health Education 8(5):36-37, September-October 1977.

A stress sheet can be a useful classroom tool to instruct students in stress-management skills. The sheet supplements instruction concerning the four steps in understanding and dealing with stress, such as understanding the theory of stress, coping with stress constructively, developing stress-management skills, and adapting to stress. The stress sheet identifies a stressful situation, adaptive coping responses, defense mechanisms, energy expended in relieving stress, sources of help, deviations used to equalize the effect of stress on the body, and physical reactions to psychologically induced pain. Students should eventually be asked to complete several stress sheets over an extended period of time and to discuss the outcomes within small student groups.

81-0969
On the Ethics of Selective Omission and-or Inclusion of Relevant Information in School Drug Education Programs.
Fors, S. W.
Journal of Drug Education 10(2):111-117, 1980.

Tradition, community pressures, and personal bias can affect a drug education program so that it constitutes indoctrination rather than education. A basic ethical issue concerns the extent to which school-aged children should be exposed to drug education strategies that selectively omit or include information about various drug issues and ideas. The arguments in favor of including all relevant information emphasize that education must not constitute an attempt to scare students for their own good; that scare tactics create paranoid students; and that educators have no right to impose their personal or cultural biases on students. Those against including all relevant information argue that educators should do whatever is necessary to prevent drug use; that educators should not increase students' curiosity about drugs; that selective inclusion of issues is in society's best interest; and that young people are not totally competent to make rational decisions about drugs. However, it seems that health education should not involve indoctrination through selective inclusion of content, and that the only instance in which such selective inclusion could be justified would be a voluntary program in which students were apprised in advance (a version of informed consent) of the specific goals of the program. 14 references.

81-0970
Integrating Nutrition Into Health Education.
German, M. J.; Pearce, J.; Wyse, B. W.; and Hansen, R. G.
Health Education 11(5):19-22, September-October 1980.

A 2-week, 10-class nutrition unit was devised, pilot tested, revised, and then field tested in 2 northern Utah high schools. The core of the unit dealt with understanding nutrition needs, evaluating foods qualitatively using nutrient density, and understanding energy balance and weight control. The nutrient density component of the unit em-

ployed the Index of Nutritional Quality (INQ), which allowed the student to examine the ratio of nutrients to calories in a particular food item. The sequential lesson plans included a detailed outline of the nutrition information to be presented, a summary of the subject content, instructional materials and equipment needed, and behavioral objectives. Instruments used in the pilot included overhead transparencies, nutrition profiles for nearly 700 foods, a slide collection on dietary effects, and 24-hour activity records to be kept by students. A 4-hour inservice workshop was provided for teachers prior to implementation of the unit. Comparison of pre- and postunit scores revealed a significant increase in students' nutritional knowledge. Interview responses by teachers were positive, particularly in reference to the INQ. 5 references.

81-0971
Selective Bibliography of Nutrition Education Materials for Preschool Instruction in Wisconsin.
Herr, J.; Gifford, J.; and Morse, W.
Madison, Wisconsin Department of Public Instruction, Food and Nutrition Services. 14 p., Spring-Summer 1980.

Citations, annotations, sources, and prices of nutrition education materials are provided for the early childhood educator, early childhood nutrition education specialist, and food service personnel. The materials include curriculum guides, audiovisual materials, posters and pictures, cookbooks for the classroom, manipulative materials, and children's books.

81-0972
Evaluation of the Effectiveness of a Drug Prevention Education Program.
Kearney, A. L. and Hines, M. H.
Journal of Drug Education 10(2):127-134, 1980.

A study involving 935 experimental students and 449 control students attending grades 2-6 in Appleton, Wisconsin, was designed to measure the effectiveness of a drug prevention education program. Thirty-six teachers of students in the experimental group received inservice training in self-esteem, values clarification and decision making, and drug information and attitudes. Each of the teachers was instructed to use the program throughout the academic year for a minimum of 1 hour per week. Teachers of control students were asked to proceed as usual with no such program activities. The Piers-Harris Children's Self-Concepts Scale was used to assess self-esteem, and new instruments were developed to measure decision-making ability, drug knowledge, and drug attitudes. Results of the data analysis, which included a reliability assessment of the instruments via alpha coefficients, indicated that children in the experimental group significantly increased (1) their feelings of self-worth, (2) their decision-making abilities, and (3) their factual knowledge about drugs. The experimental group members also improved their attitudes toward use and misuse of drugs. As a result of this study, the U.S. Office of Education has recognized this program as a national model. Presently, the program is being disseminated nationwide via the National Diffusion Network and is being replicated by schools in 25 States. 8 references.

81-0973
Young Alcohol Abusers: The Challenge of Prevention.
King, S. E.
Journal of Drug Education 10(3):233-238, 1980.

The prevention of alcohol abuse among young persons should move beyond educational programs that merely provide information about the substance and its potentially harmful effects. An alternative effort would explore underlying motivational factors that lead young persons to drink to excess. An examination of several areas of personality development, i.e. self-esteem, internal control, and coping skills, suggests prevention strategies that respond to the social and emotional needs of the young alcohol abuser. A number of prevention programs that use some of these strategies, including project ACCEPT in California and Project PRIDE in Florida, have begun to operate in high schools throughout the United States. There is a critical need for more of these programs, and a particular need in the area of early parent education. 7 references.

81-0974
The Health Activation Program: Encouraging Self Care in College Students.
Kulp, J.
Health Values: Achieving High Level Wellness 4(5):217-221, September-October 1980.

The Health Activation Program at Southern Illinois University at Carbondale is based on the assumption that people are willing to take an active role in their health care. The program focuses primarily on common ailments of the student population of 22,000. Through a variety of services, the program disseminates information and encourages greater responsibility by the students for their health. A self-care resource room located in the health service provides pamphlets, lends books, and provides a place for students to discuss their health concerns with a staff person. Programming in the dorms and the student

center emphasizes practical information on such topics as nutrition, massage, healing alternatives, and self-care treatments. A series of self-care tapes located in the library gives students concise information on symptoms, treatment, and appropriate use of the health service for problems such as venereal disease, vaginitis, sore throat, and stomach flu. One important goal of the program is to reduce the number of "low-necessity" visits to the health service by encouraging students to rely on their own self-care capabilities for minor ailments. The second goal of the program is to strengthen students' self-care behaviors via appropriate information. 6 references.

81-0975
Peer Teaching and Smoking Prevention Among Junior High Students.
Perry, C. L.; Killen, J.; Slinkard, L. A.; and McAlister, A. L.
Adolescence 15(58):277-281, Summer 1980.

A study involving 289 seventh grade students and 400 control subjects was designed to assess the effectiveness of Project CLASP (Counseling Leadership About Smoking Pressures). CLASP consists of teams of high school students who provide seventh grade classes with an intensive 3-day smoking education program, followed at 1-2-month intervals with followup sessions. A lecture on the health hazards of smoking is given during the following year (eighth grade). During the program, the junior high students commit themselves to abstinence from smoking, hear testimonials from former smokers, identify social pressures, rehearse methods to resist such pressures, and role play resistance. Evaluation of the experimental and control groups consisted of self-reports of smoking behavior over a 15-month period and carbon monoxide tests of a sample of the students. Data indicate that a smoking prevention program based on social learning principles can produce positive changes in smoking behavior. 8 references.

81-0976
Linking Health Education Content With Classroom Group Development: A Suggestion for Planning.
Weinstein, S. A.
Journal of School Health 50(9):543-544, November 1980.

An approach that links health education topics and course content to current issues facing students has been developed to allow educators to introduce health issues that are congruent to stages in classroom group development. Class groups usually move from relatively unrelated aggregates of people toward some kind of interactive relationship as students take part in participatory learning activities. This movement appears to be the formation of a group with norms, limits, and expectations held more or less in common. Not only is the staging the same for most age and grade levels, but its sequence is consistent. The typical development of a group proceeds from ambivalence about joining the group by its members, through uncertainty about leadership and authority, fear about intimacy, and conflict about acceptance, to termination and separation of the group. A curriculum approach is offered that can be developed in association with these developmental stages.

81P-0977
SWAT--Reproductive Health Education.
Thomas, L. L.
South Carolina State Department of Health and Environmental Control, Pee Dee II District, Plaza Building, Bennettsville, SC 29512
Funding Source: Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
October 1978 - September 1982.

'SWAT' is a reproductive health education program for 13-16 year olds to reduce infant mortality in the Pee Dee II Health District in South Carolina. The SWAT approach is an integrated component of Family Planning, Child Health, and Maternity Health Department programs. Program services include a 16-20-hour reproductive health education series for schools and community groups; assignment of a public health nurse to the county school system; identification, counseling, referral, and followup services for pregnant teenagers; provision of training programs in reproductive health education for teachers; and implementation of data-gathering activities. The SWAT effort is conducted by a multidisciplinary group of public health professionals who coordinate their activities with the lay medical and professional community. The evaluation component of the program consists of pre- and post-course tests, teacher and student evaluation, and a longitudinal followup.

81P-0978
Teen Social Behavior and the Prevention of Smoking.
Biglan, A., et al.
Oregon Research Institute, 1009 Patterson St., Eugene, OR 97403
Funding Source: National Inst. of Child Health and Human Development (DHHS, NIH), Bethesda, Md.
August 1979 - July 1981.

"Teen Social Behavior and the Prevention of Smoking" is designed to (1) analyze teenage social influence processes as they relate to the adoption and maintenance of smoking and (2) develop and evaluate a smoking prevention and cessation program for teens based on that analysis. A questionnaire was developed to identify attitudes, social influences, and situations that affect teen smoking and to establish criteria for assessment. Breath samples and thiocyanate levels in saliva were measured as a validation of this information. In addition, several small observation and self-monitoring studies were completed to further isolate smoking contingencies. Using this information, pilot programs are being developed and tested that rely heavily on the use of high school students who lead group discussions and teach refusal behavior to seventh graders. The program is developing a high school curriculum designed to deter smoking among nonsmokers and recruit smokers into cessation programs. By the end of a 3-year period, the program will have tested these components with 7th and 10th grade students in a controlled experimental design. Treatment packages also will have been tested by using a controlled experimental design, with 780 ninth grade students.

SELF-CARE

81-0979
Evaluation of a Community-Based Education Program for Individuals With Chronic Obstructive Pulmonary Disease.
Ashikaga, T.; Vacek, P. M.; and Lewis, S. O.
Journal of Rehabilitation 46(2):23-27, April-June 1980.

"Breathing Workshops," the Vermont Lung Association's community-based group education program, was evaluated to assess its success in promoting the development of preventive and restorative health care behaviors in persons with chronic obstructive pulmonary diseases (COPD). The program's six sessions are attended by persons with COPD and their families. Sessions present factual information, demonstrate self-help skills, and offer group discussion opportunities dealing with the psychosocial aspects of living with COPD. In the evaluation, a group attending the program and a control group were administered questionnaires prior to and 4 months after the program. Results indicated that participants increased their understanding and knowledge of COPD, their readiness to seek health care, and their compliance with self-help activities. Some of these changes were not statistically significant when compared with the control group. Changes in control group members included a decrease in their perceived chance for improvement. 16 references.

81-0980
Pointing Diabetics to Mutual Self-Care.
Fuller, E., ed.
Patient Care 14(5):208-226, March 15, 1980.

The Diabetes Club at the Greenwich Hospital in Greenwich, Connecticut, exemplifies the success of mutual self-care efforts in diabetes control. Members of the club express a need for encouragement from other diabetics in accepting their condition and maintaining control of hyperglycemia. Some members complain about not receiving enough information and literature from their physicians. To help improve diet, the club notifies members concerning diabetic cookbooks and reinforces compliance. Group reinforcement and the exchange of experiences about the diabetic's life help members avoid pitfalls and overcome depression. The inclusion of family members at the meetings has been highly successful.

81P-0981
Association for Brain Tumor Research.
Segal, D.
Suite 200, 6232 North Pulaski Road, Chicago, IL 60646
1973 - Continuing.

The Association for Brain Tumor Research provides support, educational materials, means to achieve coping skills, and a constructive outlet for anger and frustration to patients, their families, and friends. The association sponsors the formation of self-help groups of patients by furnishing a variety of printed materials for the groups, including a quarterly newsletter and educational materials. Affiliated groups promote activities that are designed to raise the level of public awareness in the local community and to raise funds for further brain tumor research. A handbook is available to explain in detail how an affiliate can be formed under terms acceptable to the affiliate and to the national office. Qualified research centers and lay persons can request information from the association, including a listing of experimental treatment centers and brain tumor study groups; "Brain Tumor Research Review," which is updated and published annually; "Radiation Therapy," a pamphlet designed to assist patients recommended for radiation; and "Living With a Brain Tumor," a pamphlet listing books and organizations designed to help persons cope with chronic or terminal diseases. The association has also published a 40-page brain tumor primer for patients and their families. The association is staffed by skilled volunteers, and the medical advisory council provides professional guidance.

81P-0982
Learning to Care for Children With Diabetes.
Turano, V.
Metro Denver Juvenile Diabetes Foundation, 8126 E. Long Place, Englewood, CO 80112
Funding Source: Colorado Motor Carriers Association, Denver, Ladies' Auxiliary.
Continuing.

"Learning to Care for Children With Diabetes" teaches babysitters to care for diabetic children. The 2-hour class is designed for 10-15 potential babysitters and is taught by nurses trained as diabetes educators. It includes a discussion of nutritional necessities, urine testing, insulin use, hypoglycemia, and general first aid. A babysitter's handbook is provided to course participants. The names of students who have completed the course are placed on a referral list which is mailed to any parent who inquires. Since the first class in October 1978, 50 Denver-area adolescents, who were recruited by parents of diabetic children, have completed the course. Parents evaluate the adolescents' ability to care for the children; feedback from parents indicates that the babysitters have demonstrated ability and responsibility.

SEX EDUCATION

81-0983
Sex Education in a Rural High School.
Gumerman, S.; Jacknik, M.; and Sipko, R.
Journal of School Health 50(8):478-480, October 1980.

A sex education program for high school sophomores was initiated by the outreach staff of a rural health center in southern Illinois. The four 1-hour sessions included an exercise to demonstrate decision-making processes, a presentation to explore the definitions of love and sex, discussion of the choice to be sexually active, discussion of reasons for becoming pregnant and options to those who become pregnant, an exploration of the various methods of birth control, an explanation of the pelvic examination procedure, and an informal group discussion of written questions and comments from students. A one-page evaluation form was given to students to allow them to comment on the speakers, format, and unit content. In addition, a pre- and posttest to assess changes in students' knowledge and an adaptation of Conley and Haff's sex information survey were designed to determine whether the unit contained topics of interest to the students. Results of these instruments indicated that (1) students favored the use of more audiovisual aids and separation of sexes during the course; (2) students demonstrated significant gains in knowledge after the program; (3) more time should be devoted to each topic; and (4) sex education should be incorporated into a family life course.

81-0984
Modern Sex Education.
Julian, C. J.; Jackson, E. N.; and Simon, N. S.
New York, Holt, Rinehart and Winston, 90 p., 1980.

A high school sex education textbook is presented that attempts to provide an attitude-centered approach, encouraging a personal value system based on regard for others. Each chapter includes motivational opening questions, objectives, phonetically spelled vocabulary words, summaries, and activities. Topics include family life, crucial changes during adolescence, human relationships, reproduction, family planning, sexual variance, sexually transmitted diseases, and healthy sexuality. A glossary is appended.

81-0985
Midlife Women in College Sexuality Classes.
Sheppard, S.
Journal of the American College Health Association 29(2):81-82, October 1980.

A study involving 47 women 35-60 years old who elected to enroll in human sexuality classes for students in the Adult Collegiate Education program at Queens College in Flushing, New York, was designed to assess these students' goals and perceived problems. At the beginning of the semester, the students filled out a questionnaire that elicited information regarding age, marital status, number of children, reasons for enrollment, and topics of greatest interest. Each of the students also wrote, at the beginning and end of the semester, an anonymous paper on their own sexuality and completed an anonymous evaluation questionnaire on the course. Results of these exercises indicated that problems at the beginning of the semester focused on guilt, anxiety, resentment, inhibitions, and ambivalence regarding sexuality. As a result of the course, 91 percent of the women reported that positive changes had occurred in their feelings about themselves and their sexuality, their understanding of their partners' needs, their ability to communicate about sex, their acceptance of their children's sexuality, and their empathy for people whose sexual orientations differed from their own. The course reveals that middle-aged women can benefit from educational experiences that provide the opportunity to gain information and knowledge about sex and to air concerns and questions. 7 references.

81-0986
Sexual Instruction for the Mildly Retarded and Normal Adolescent: A Comparison of Educational Approaches, Parental Expectations, and Pupil Knowledge and Attitude.
Watson, G.
Health Education Journal (London) 39(3):88-95, 1980.

A three-pronged study was designed to assess the attitudes and desires of educationally subnormal (ESN) adolescents, their parents, and their teachers concerning sex education. The controlled study involved (1) a mail survey of 231 teachers of ESN children and 104 teachers of normal children, (2) visits to 32 schools to assess teachers' attitudes and courses taught, (3) a survey of 194 ESN students and 61 educationally normal students, and (4) interviews with 93 parents of ESN children. Findings from these research methods indicated that (1) ESN children lag behind their normal peers in sexual knowledge, (2) ESN teachers place greater emphasis than teachers of normal children on topics associated with human relationships, (3) teachers of normal children place greater emphasis than teachers of ESN children on factual topics concerning conception and contraception, (4) head teachers of ESN schools have gained the cooperation of all those who could influence the implementation of a sex education program, (5) most ESN schools lack teaching materials suitable for ESN students, and (6) parents of ESN children accept their children's sexual conservatism and ignorance. Nevertheless, the ultimate goal of enabling ESN children to break away from adult dependence and to experience normal adolescent rebellion and sociosexual relationships cannot be reached under present conditions. 9 references.

81P-0987
Community-Based, Parent-Centered Sexuality Learning Program.
Stackhouse, B. and Whitney, B.
Sex Information and Education Council of the U.S. (SIECUS), 84 Fifth Avenue, Suite 407, New York, NY 10011
Funding Source: William Penn Foundation, Philadelphia, Pa.
November 1980 - May 1983.

The Community-Based, Parent-Centered Sexuality Learning Program develops programs for parents of children up to 12 years old to enhance parents' ability to respond to their children's questions and psychosexual development. The program works with community organizations with an established parent constituency. Thus far, the program has formed a community advisory committee to identify community needs and provide support to the program. Programs available to parents in the community agencies will range from informal opportunites to speak with a community sex educator to more formal learning programs. An audiovisual unit has been developed that offers information on sex and sexuality to parents who are coming into the agency to browse. These services are directed at the Italians, blacks, Poles, Jews, and upper middle class whites who compose the south Philadelphia area. The program works closely with CHOICE, a local community agency that has already established significant contacts in Philadelphia in the area of parent sex education. Evaluation strategies are being developed with the cooperation of the professional evaluation staff of the Family Planning Council of Southeastern Pennsylvania.

81P-0988
Family Life Education Program for Urban, Out-of-School Girls of Baroda City.
Verma, A.
Maharaja Sayajirao University, Baroda, Faculty of Home Science, University Road, Baroda-390002, India
February 1978 - Continuing.

The Family Life Education Program for Urban, Out-of-School Girls of Baroda City provides family life education to unmarried adolescent women who do not attend school. Services include (1) training staff of family welfare clinics to provide advice and service in family planning, and (2) coordinating clinic staff and volunteer youth workers who offer information and counseling to adolescent women. Program staff hold informal discussions with the mothers of target group women and conduct semistructured interviews with target group women to collect data on nutrition, child care, housing, clothing, and related family life concerns. These base-line data allow preparation of a learning package and presentation of a family life planning program in various communities by trained community workers. Audiovisual materials and lesson plans are being developed for inclusion in the learning package. The program will cover various communities in Baroda City, involving 25-30 adolescent women in each community. Four full-time staff members provide all paraprofessional training services and establish coordinative liaisons with local organizations that operate similar programs. Thus far, there is no formal evaluation.

81P-0989
Planned Parenthood of Rochester and Monroe County, Inc., Education Programs.
Krell, M. E.
Planned Parenthood of Rochester and Monroe County, Inc., 24 Windsor Street, Rochester, NY 14605
Funding Source: Department of Health and Human Services, Washington, D.C.; New York State Dept. of Health,

Albany. Bureau of Family Planning; New York State Dept. of Social Services, Albany.
Continuing.

The Planned Parenthood of Rochester and Monroe County (New York) Education Programs inform teenagers, preteenagers, and their parents about human sexuality and birth control. The program developed, published, and distributed curricula for preteens and teenagers and guidelines for parents and teachers. In addition, the program has implemented a graduate-level teacher training course, which has become a statewide model, and multisession training programs for individual agencies based on staff needs. Grants have also been received to (1) train foster parents under the supervision of the State Department of Social Services in topics related to teen pregnancy and (2) enhance the inner-city community education program in Rochester by establishing an in-school rap room for students, coupled with informal evening sessions for parents in their homes. All programs target preteenagers, teenagers, and their parents and teachers living in Monroe County, which has a population of 708,642. Over 400 copies of the curriculum have been distributed throughout the county. Teacher evaluations have been positive.

81P-0990
The Stork Is Dead: Telling Your Child About Sex.
Adams, C. and Roberson, E.
Edgecombe County Health Department, Health Education Division, Tarboro, NC 27886
March 13 - April 10, 1980.

"The Stork Is Dead: Telling Your Child About Sex" was designed to help parents talk comfortably with their children about growing up physically, emotionally, and socially. Five weekly 2.5-hour evening classes included lecture, role play, discussion, learning activities, audiovisual presentations, and a values-clarification handbook. Six parents attended the sessions. The instructors included two health educators from the county health department and a child development specialist from the Edgecombe-Nash Mental Health Center. A photographer from the Edgecombe Technical College provided technical expertise and equipment to help make the slide show, and a local radio station recorded a medley of songs used in the program. Pre- and postprogram tests were administered to participants to measure factual knowledge gained and attitude changes. In addition, a course questionnaire was administered to evaluate class climate, instructors' competencies, the efficacy of learning strategies, and the effects of other aspects of the course. Several participants stated that they would like to participate in future programs.

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81-0975

PROJECT PRIDE
81-0973

PROJECT WELL AWARE ABOUT HEALTH
81-0877

THE STORK IS DEAD: TELLING YOUR CHILD ABOUT SEX
81P-0990

STUDENT WELLNESS RESOURCE CENTER
81-0967

SUDDEN INFANT DEATH SYNDROME COUNSELING AND INFORMATION PROGRAM
81P-0838

SWAT--REPRODUCTIVE HEALTH EDUCATION
81P-0977

TEEN SOCIAL BEHAVIOR AND THE PREVENTION OF SMOKING
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THINK HEALTH
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UNIVERSITY OF NEW MEXICO DENTAL PROGRAMS
81-0915

WE CARE FOR YOU
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WELLNESS OUTREACH PROGRAM
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X RAYS: GET THE PICTURE ON PROTECTION
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YOUTH GIVES A DAMN (YGAD)
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CURRENT AWARENESS IN HEALTH EDUCATION

SEPTEMBER 1982, Part 2

81-0991—81-1143

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COMMUNITY HEALTH EDUCATION

81-0991

Health Education and the Black Community (Report of a Meeting Held July 26-27, 1979, at the Bureau of Health Education, Center for Disease Control, Atlanta, Georgia 30333).

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 82 p., December 1980.

A conference on "Health Education and the Black Community" was held July 26-27, 1979, at the Bureau of Health Education. During the conference, position papers were offered on the relevance of health education theories and their application to the black community, the impact of health education on black communities without changes in the external environment, the role of the health education process in improving the health status and quality of life in the black community, methodological and substantive issues in health education programming, school health education in black communities, health promotion among black populations, perspectives on health education and health promotion in the "black belt," competencies needed by health education personnel engaged in service to black communities, a categorical approach to comprehensive health promotion and disease prevention aimed at management of hypertension, prerequisites for health education in the black community, and health career development. Appendices include a participant roster, a list of issues that participants considered to need attention, and the agenda of the conference.

81-0992

Model Standards for Community Preventive Health Services: A Report to the U.S. Congress From the Secretary of Health, Education, and Welfare.

American Public Health Association, Washington, D.C.; Association of State and Territorial Health Officials, Washington, D.C.; National Association of County Health Officials, Washington, D.C.; United States Conference of City Health Officers, Washington, D.C.; and Centers for Disease Control (DHEW, PHS), Atlanta, Ga.

Washington, D.C., Office of the Assistant Secretary for Health and Surgeon General, DHEW, 110 p., August 1979.

Model standards covering 28 program areas related to community preventive services are presented. In addition to preventive service delivery, the standards address some of the regulatory aspects of prevention, such as environmental health. Program areas covered include administrative and support services, air quality, chronic disease control, communicable disease control, dental health, emergency medical services, family planning, food protection, genetic disease control, health education, home health services, housing services, injury control, institutional services, maternal and child health, noise control, nutritional services, occupational health, primary care, public health laboratories, radiological health, safe drinking water, sanitation, school health, solid waste management, surveillance and epidemiology, vector and animal control, and wastewater management.

81-0993

Family Life Theatre and Youth Health Services.

Boria, M. C.; Welch, E. J.; and Vargas, A. M.

American Journal of Public Health 71(2):150-154, February 1981.

The Family Life Theatre, which is integrated into the Youth Health Services of New York Medical College, uses improvisational theater to address personal growth, sexuality, drug use, alcoholism, contraception, human relationships, and other topics of interest to community adolescents. Implemented in 1973 as a health education program, the pilot project has been replicated by many groups and institutions across the country. Under the supervision of a theatre instructor, a cast of teenagers 14-18 years old writes, produces, and performs stage events. Training for the actors, who represent a cross section of New York City youth, includes health education seminars and instruction in improvisational theater. Participation by audiences, which range from 50 to 500 persons, is encouraged through a dialog at the end of the play. Over 300 plays have been presented in the last 3 years, and the theater has received supportive publicity from local media. The theater seems to have (1) increased utilization of the Youth Health Services and (2) inspired the formation of at least 15 similar theater groups as well as numerous other adolescent health education programs.

81-0994

Nutritional Disorders of Children: Prevention, Screening, and Followup.

Foman, S. J.

Rockville, Md., Health Services Administration, Bureau of Community Health Services (DHEW Publication No. (HSA) 78-5104), 123 p., 1978.

Available from: GPO: Stock No. 017-022-00514-0.

Guidelines are presented to help health care providers improve preventive efforts related to nutrition problems in children and adolescents. Part I outlines the screening process for identifying nutritionally at-risk children, and part II covers prevention of four major childhood nutritional disorders: obesity, atherosclerosis, dental caries, and iron-deficiency anemia. Numerous references.

81-0995
Health Education Assessment Survey: The Florida Panhandle, December 1978.
Ford, W. S. and Ford, A. S.
Atlanta, Ga., Center for Health Promotion and Education (DHHS, CDC), 155 p., August 1979.

The Florida Panhandle Health Education Resource Center (HERC), with partial funding by the Bureau of Health Education, contracted with the Institute for Social Research at Florida University to conduct a model, population-based household survey in the Panhandle Health Systems Agency and a survey of the area's primary care physicians. The household survey was designed to determine the health knowledge, attitudes, practices, and health status of the Panhandle population; the physician survey was designed to assess the extent and type of education provided by the physicians and to discern their receptiveness to working with HERC. Volunteer interviewers gathered data in the household survey in the Panhandle health services area and a survey of the area's primary care physicians. The questionnaires were mailed to all practicing primary care physicians in the area. The questionnaires were accompanied by endorsement letters from the Capital City Medical Society; the mailing was followed by a second mailing to nonrespondents and a subsequent mailing of a postcard reminder. Completed questionnaires were returned from 103 of the 230 targeted physicians. Major findings of the two surveys indicated that (1) 50 percent of the physicians believed that the average patient had inadequate health knowledge; (2) household respondents had a generally uneven grasp of important disease indicators; (3) most household respondents were able to identify a source of health care in the community; (4) 57 percent of the physicians believed that patients were not interested in health education; (5) physicians did not realize the high value assigned to personal health by the population; (6) only 32 percent of the physicians were considering greater participation in health education activities; and (7) 39 percent of the physicians were willing to cooperate actively with HERC.

81-0996
Development of Dental Health Education: The Contribution of the Dental Board.
Fox, B. and Maddick, I.
British Dental Journal (London) 145(11):339-344, December 5, 1978.

Organized dentistry in Great Britain, from the establishment of the British Dental Association in 1880, is reviewed. Topics include (1) the formation of the School Dentists' Society in 1897 to promote regular oral hygiene instruction in the school system by making educational materials available for lecturers and teachers; (2) the Dentists Act of 1921, which provided for the use of surplus income for dental education and research; (3) the establishment of the Dental Health Committee in 1923, which embarked on a dental health education program for the general population and established the pattern for future dental health education in Britain; and (4) the Committee's involvement and subsequent withdrawal from the service aspects of dental health education, which led to acceptance by the government of greater responsibility for dental health promotion. 12 references.

81-0997
Fluoride's Role in Health Promotion: A National Perspective.
Iverson, D. C.
Journal of Public Health Dentistry 40(3):276-283, Summer 1980.

An effective national dental health promotion program would promote the fluoridation of all community water supplies, fund fluoridation equipment, strengthen school programs in dental health education, collect research data on programming, expand behavioral science research into factors associated with health-related behavior, and supply national leadership to stimulate visibility and commitment to improved dental health. The components of this diversified approach must adhere to the basic principles of free choice, apply regulations in a prudent manner, and avoid coercive techniques. Health promotion and education must be used together on several organizational, political, and economic levels to allow the achievement of a synergistic effect. 24 references.

81-0998
Mental Health Primary Prevention: The Role of Parent Mutual Support Groups.
Kagey, J. R.; Vivace, J.; and Lutz, W.
American Journal of Public Health 71(2):166-167, February 1981.

A perinatal task force of community groups and agencies organized by the Greater Lynn, Massachusetts, Community Mental Health Center's Primary Prevention Team developed a pilot support group for new parents. The program, which was implemented in cooperation with a regional maternity center, employed volunteer facilitators who attended prenatal classes at the Center to become acquainted with parents. Training for facilitators consisted of eight 150-minute sessions on the birth experience and two sessions on communication and group process. Following deliveries, the facilitators invited the new parents to join one of the support groups. The support groups have five to eight members who follow no set format. There are now 28 ongoing groups, including a group for fathers, a group for mothers with problem infants, a group for mothers who have delivered by cesarean section, and a group that serves mothers living in a low-income area. The program is reinforced by a series of monthly educational programs and a newsletter. A survey of 270 parents undertaken 2 years after the program's initiation indicated that the program was a viable tool for primary mental health care. 5 references.

81-0999
Community Partnership Organizations: A Better Way to Gain Participation in Health Programs.
MacNair, R.
Atlanta, Ga., Center for Health Promotion and Education (DHHS, CDC), 33 p., November 1980.

Guidelines for forming, organizing, and delivering community partnership organization (CPO) services are provided to those interested in developing citizen support of and participation in local public health agencies. Four basic and practical models are available for structuring CPO's; three can be used in health education and prevention programs. Other topics include choosing a facilitator, choosing and training personnel, convening a steering committee, selecting representatives, planning the structure, organizing leadership, helping citizen groups organize, organizing disadvantaged citizens, maintaining participation, working with citizens via specific techniques, organizing the interagency council, organizing the CPO council, and understanding the roles of citizen groups and agencies.

81-1000
Family Physicians and Radio Broadcasting.
Martin, M.
Journal of Family Practice 11(4):665-666, October 1980.

Three Massachusetts physicians developed a weekly, 45-minute radio program entitled "Call Me in the Morning," which encourages telephone calls from listeners. The program concentrates on demystification of medical subjects, health education, preventive techniques, self-care, consumerism, and alternative healing methods. A specific topic and guest speaker is scheduled for each broadcast. The use of musical segments and dramatic case presentations has proven helpful in making the program entertaining as well as informative.

81-1001
Children as Teachers of Dental Health Education.
Plamping, D.; Thorne, S.; and Gelbier, S.
British Dental Journal (London) 149(4):113-115, August 19, 1980.

The St. Thomas Health District Community Health Council of Kennington, England, implemented a program to train 5- to 15-year-old children to act as peer dental educators. The program began by training 50 children who came to one or more weekly sessions during a 6-month study period. Training activities included a visit to a community health clinic, an interview with a dentist, demonstrations of the use of plaque-disclosant, poster and model making, letter writing, and game designing. The children taught in a variety of settings: a baker's shop, dentists' waiting rooms, general practitioners' waiting rooms, cub pack meetings, preschool nurseries, infants' schools, youth club meetings, and meetings of prospective new teachers. The children's experiences enabled them to (1) understand problems associated with teaching, (2) compile a file of material related to their activities, (3) gain knowledge about dental matters, and (4) deal effectively with their peers and adults. 4 references.

81-1002
Answering the Call for Health Information.
Sager, D. J.
American Libraries 9(8):480-482, September 1978.

Using a $30,000 Library Services and Construction Act grant from the Ohio State Library, the Public Library of Columbus and Franklin County established the "Health-Line" audiotape library, which offers health information via telephone to community residents. Like similar programs in 70 other cities, the library purchased their TEL-MED tape library from its developer, the San Bernardino (California) Medical Society, which has produced 300 3-5-minute tapes on health-related topics. The library spent $11,000 for the equipment and $5,000-6,000 for the tapes. A moderate multimedia publicity campaign was

mounted and enough telephone lines were leased to allow the system to deal with a population of 833,000. Daily use of Health-Line peaked at 800 calls shortly after program initiation, declined to 500 calls after several months, and is likely to decline to 300 calls after the program has become fully established. The most frequently requested tapes deal with information on sex. The reviewing process by the local medical society, a process which is required by TEL-MED, was time consuming but beneficial to programming.

81-1003
Educators in Action: Two-Day Health Fair.
Stanton, F.
Texas Hospitals 36(5):23-24, October 1980.

Hurst-Euless-Bedford Hospital of Bedford, Texas, held a 2-day health fair to introduce the community to the concept of wellness. The fair provided multiple health screening tests, individual counseling, and information on health education and awareness of local health and social resources. The planning committee consisted of representatives from various hospital departments and the local representative of the National Health Screening Council for Volunteer Organizations, a nonprofit organization that developed and implemented the health fair model. The fair was held in an area of the hospital with easy parking access. Participants completed health appraisal questionnaires, received a series of screenings, filled out an evaluation questionnaire, and received an explanation of screening procedures. All participants received test results within 6 weeks of the fair. The hospital's education department provided a self-directed exhibit on stress reduction. Games were staged to give the fair a festive atmosphere.

81-1004
Guidelines for a Community Health Education Program in a Correctional Setting.
Stelling, F. H. and Trisdale, D. J.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 25 p., (197-).

Guidelines for a community health education program in a correctional setting are provided for correctional and health education professionals. The guidelines were developed from the experiences of two health education projects that were organized and implemented by the Tennessee Department of Public Health. In planning a program, promoters should develop a clear statement of the program's purpose, involve community leaders, involve personnel of the State Department of Corrections and the institution, and involve the institution's residents. Analyzing problems to be addressed by the program requires compiling statistical data, examining descriptive and subjective information, and involving the community in decisions concerning program priorities. The four phases involved in development of the actual program are selecting problems to be addressed, identifying objectives, selecting and developing subobjectives, and selecting resources and activities. Program implementation centers on staff training and organization of activities. Process, effectiveness, and efficiency evaluation should be part of the design throughout. Lists of resources outside the institution, lists of sources of data for community analysis, and a selected bibliography are appended.

81-1005
The Health Education Center, Pittsburgh, Pennsylvania.
Sullivan, D. A.
Atlanta, Ga., Center for Health Promotion and Education (DHHS, CDC), 27 p., 1979.

The Health Education Center is a project of the Health and Welfare PLANNING Association (HWPA), a United Way agency in Pittsburgh, Pennsylvania. The Center, which serves a 10-county area with a population of 3 million, provides information, technical assistance, and direct education to consumers, public and private health and educational organizations, and business and industry. Formation of the Center began with a recommendation in 1971 by the HWPA Health Task Force for stronger community-wide health education, a regional hearing on health education needs and resources called by the chairperson of the President's Committee on Health Education in 1972, a community meeting in 1973 to examine the recommendations of the hearing, and publication of guidelines by the HWPA and the Comprehensive Health Planning Association in 1974. Roundtable discussions by representatives of public and private institutions, a health education conference, and submission of a proposal for a 3-year grant of $180,000 in 1975 preceded the opening of the Center in 1976. The Center's major functions are program development, provision of information and communication services, and evaluation of and research on health education programs in the region. In addition to approximately 30 volunteers, the staff includes 8-11 professionals representing competencies in administration, communication, community organization, evaluation, health education, nursing, and planning.

81-1006
A Recipe for Health.
Thomas, S.
Nursing Mirror (Sussex) 150(14):30-31, April 3, 1980.

Senior health officers who serve British communities provide a wide range of services, including health education presentations to civic groups of adults and children, formal educational sessions for nursing students, maintenance of health records, visitations and phone contacts to maintain liaisons within the local health services network, dissemination of educational materials, and health instruction at local schools.

81-1007
Changing Nutritional Behavior by Aides in Two Programs.
Wang, V. L.
Journal of Nutrition Education 9(3):109-113, July-September 1977.

A 5-year study examined the Expanded Food and Nutrition Education Program (EFNEP), which uses aides to effect changes in dietary practices, and its sister program, the Family Aid Program (FAP), which provides nutrition education to families as part of a more generalized approach. Both programs, which are funded by the U.S. Department of Agriculture, target low-income families with young children. Each highlights the problems and issues in deploying aides as teaching agents. Examination of the current means of deploying aides, who act as homemaking teachers or nutritional aides, indicated that the aide can be an effective agent in changing the dietary practices of homemakers. However, the aide's potential for an expanding role has yet to be realized. Present on-the-job training lacks standards and gives little encouragement to career mobility, resulting in high turnover rates. Intensive training modeled after a practical nursing program, with carefully defined roles and role behavior combined with a curriculum designed for accreditation and licensing, could prepare the aides as paraprofessionals. This improvement would upgrade standards and contribute to personnel development. 13 references.

81-1008
Attacking the Drug Norm: Effects of the 1976-77 Florida Drug Abuse TV Campaign.
Wotring, C. E.; Heald, G.; Carpenter, C. T.; and Schmeling, D.
Journal of Drug Education 9(3):255-261, 1979.

During 1976 and 1977, the Florida Drug Abuse Program (FDAP) staged a statewide public awareness campaign via television to bring into question the publicly accepted norm of using prescription and nonprescription drugs for a variety of problems. After an assessment of the target audience by the Communication Research Center of Florida State University, the FDAP generated 10 campaign ideas for public service announcements, which were submitted to the National Clearinghouse for Drug Abuse Information for pretesting among target group subjects, media experts, and the general population. As a result of this analysis, 3 public service announcements were developed and broadcast 223 times by 5 stations serving the Tallahassee area. Evaluation of the program's impact involved telephone interviews with 960 randomly selected heads-of-household in the area. Results of the interviews indicated that (1) 51 percent of those polled viewed at least one announcement; (2) viewers tended to be young females; and (3) viewers were more likely than nonviewers to mention that legal drugs are abused, respond that everyone is responsible in the fight against drug abuse, believe that anyone can abuse drugs, and agree with the statement that people regularly use drugs. 2 references.

81P-1009
Aztlan Community Services, Inc.
Hunsaker, A. and Vicario, T. 718 E. Maitland Avenue, Ontario, CA 91761
1974 - Continuing.

Aztlan Community Services of Ontario, California, is a private, nonprofit, community-based organization dedicated to resolving poverty-related problems among the residents of western San Bernardino County. Beginning with a small, outpatient counseling program, Aztlan has grown to include programs for mental health counseling, alcoholism counseling, school-based substance abuse prevention, community conservation, and a youth service bureau. The bureau works mostly with preteens who are not yet identified as delinquents. Tutor-counselors working with as many as 20 children promote attitude changes and support children's efforts in school. An interaction component brings together children from different neighborhoods in order to limit gang violence. The bureau provides outpatient counseling and job development services. For those over 21 years old, the youth service bureau provides parent effectiveness training. To provide jobs for drug abuse and mental health clients, an oral history project was funded by the California Arts Council that focused on the lives of local elderly Chicanos. A set of learning objectives and lesson plans for use with elementary and junior high school students has been developed.

81P-1010
Community Health Participation Program.
Kohn, S.
Montefiore Hospital and Medical Center, Department of Social Medicine, 111 East 210th Street, Bronx, NY 10467
1975 - Continuing.

The Community Health Participation Program is designed to improve the health of the community surrounding the hospital by training volunteer health coordinators to work with community members on a variety of health issues. The health coordinators, who are peers of the service audience, take blood pressures, perform cardiopulmonary resuscitation, give first aid, lead workshops on nutrition and other health topics, assist groups seeking to improve the safety and amenities of buildings and the neighborhood, and help people utilize the health care and social services systems more effectively. Health coordinators are trained in a 16-session course, which is followed by regular meetings and seminars. Health coordinators work in their apartment buildings with other community groups and with various hospital departments. The program operates in Bronx health areas 4.10 and 3.10, each of which has a population of approximately 30,000. The area serves ethnically diverse low- and middle-income urban neighborhoods. The program director has a master's degree in public health. The staff consists of 61 health coordinators 20 to 70 years old who live in 43 apartment buildings housing a total of 7,500 residents. The program coordinates its efforts with several community groups, including organizations for the elderly, church groups, synagogue groups, and parent-teacher associations. The program is funded by the hospital, private foundations, and the Federal Government.

81P-1011
Family Life Theatre.
Welch, E. J., Jr.; Vargas, A. M.; and Boria, M. C.
New York Medical College, Department of Obstetrics and Gynecology, 1901 First Avenue, Room 417, New York, NY 10029
1974 - Continuing.

The Family Life Theatre employs teenage actors to convey information to teenagers about parent-child relationships, love, sex, drugs, authority, and other topics. Using improvisation, the theater troupe selects true-to-life situations and prepares scenes that reflect its views of the problems. After each performance, the group participates in a discussion with the audience. The 10-week training period for members includes instruction in improvisational theater and seminars in health education. The health seminars, which are presided over by faculty of the New York Medical College, cover human reproduction, sexual identity, menstruation, contraception, pregnancy, abortion, venereal diseases, drug use and abuse, alcoholism, parenthood, and nutrition. Though the original theater only serves groups in the New York City area, interested groups from throughout the United States and Canada are developing similar programs. The New York group performs for schools, community groups, professional conferences, and television audiences. The program requires a full-time artistic director and three assistants, a part-time producer, and a secretary. Staff of the Youth Health Services of New York Medical College think that the theater group has been responsible for the dramatic increase in use of clinical services by area adolescents. Numerous other youth-oriented city programs have been implemented as a result of impetus supplied by the theater.

81P-1012
Health Education for Youth (HEY) Program.
Jones, J. E.
College of Physicians and Surgeons of Columbia University, Center for Population and Family Health, 60 Haven Avenue, New York, NY 10032
1979 - Continuing.

The Health Education for Youth (HEY) Program is designed to improve adolescent health care through education and clinical services, with particular emphasis on pregnancy and venereal disease. HEY operates in tandem with the Young Adult Clinic, which provides physical examinations, birth control devices, pregnancy testing, venereal disease testing and treatment, gynecological care, referral services, drug abuse counseling, job counseling, dental education, and a forum for rap sessions. HEY complements these services by working intensively with community groups to develop and expand health services for teens. HEY has implemented a number of community outreach activities and instruments, including health fairs, a mobile health van, a peer education program, a program for Hispanic families, a bilingual teenage theater troupe, and a community health advocacy program. The target audience is the teenagers living in the Washington Heights area of New York City, a multiethnic, low-income community with serious health needs. The bilingual (Spanish-English) HEY staff includes a director, an assistant director for women's health, a counseling coordinator, five counselors, a nurse-midwife, an assistant education director, a clinic director, an assistant clinic director, an education director, and a health educator. The director and the clinic director are physicians. The program is run as a collaborative effort between the Center for Population and Family Health at Columbia University and the Obstetrics and Gynecology Service of

Presbyterian Hospital. The project includes a thorough evaluative component to document changes in knowledge, attitudes, behavior, and skills in the target population. Funding for HEY is derived from several organizations, including the U.S. Department of Health and Human Services.

81P-1013
Health Maintenance-Health Improvement Program
Stransky, F. W. and Arends, J.
Oakland University, Rochester, MI 48063
1977 - Continuing.

Oakland University's Health Maintenance-Health Improvement Program is designed to prevent long-term disease, improve the quality of life, and increase longevity of interested students and community participants. The program is supported by the Pioneer Athletic Club and the Department of Physical Education and Athletics. The program has cardiovascular fitness, weight control and nutrition, and lifestyle education components. Methods include periodic laboratory evaluations; personal counseling on exercise, diet and nutrition, lifestyle, self-abuse behavior, and stress management; regular exercise programming; a quarterly newsletter; and periodic seminars. Annual membership costs $250 and includes one laboratory evaluation and consultation per year, supervised exercise programs, sports center privileges, and a subscription to the newsletter. Program staff include a director with a doctorate degree, a physician who serves as medical director, a consulting physician, and a specialist in sports medicine.

81P-1014
HealthWise.
Millman, M.
New Jersey Hospital Association, Council on Auxiliaries, Center for Health Affairs, 760 Alexander Road, Princeton, NJ 08540
August 1979 - Continuing.

HealthWise is designed to help hospitals meet the health education needs of their consumers, particularly the needs of specific target audiences such as the elderly, the handicapped, and children. Information and services are distributed through a mobile health education system housed in a 32-foot van, which travels to hospitals and public gathering places. The system offers printed and audiovisual educational materials and is run by a professional staff. Programs are currently available on a variety of topics, including stress, immunization, nutrition, safety, substance abuse, physical fitness, weight control, and breast self-examination. HealthWise services are available to all hospital service populations in New Jersey. Programs may be sponsored by a hospital or hospital-related organization, and cosponsors such as health departments, parent-teacher associations, or private businesses can cooperate in programming. A field director helps the sponsor select and conduct programs for various target audiences. The cost of sponsoring a program for one day is $350; the second consecutive day costs $300; and each additional day costs $250.

81P-1015
Know Your Limits (KYL).
Gavaghan, P. F. and Smolens, A. H.
Distilled Spirits Council of the United States, Inc., 425 Thirteenth Street, N. W., Suite 1300, Washington, DC 20004
Continuing.

The "Know Your Limits" (KYL) program is designed to reduce traffic accidents that result from alcohol use. The program is administered by a private, nonprofit, national organization of distilled spirits wholesalers. KYL's strategies vary by locality but concentrate primarily on information and awareness campaigns. The key element of the program is the distribution of a wallet-sized risk card, showing the relationship between (1) time between drinks, body weight, and amount of alcohol consumed, and (2) the effect of these factors on driving ability. Distribution of these risk cards through local distilled spirits distributors is reinforced by television and radio campaigns and displays and booths at shopping centers, county fairs, and other public gathering places. Brochures and guidelines are available for those interested in implementing the program in their State or locality. The campaign has been conducted in 27 States and the District of Columbia, and by the U.S. Department of Transportation. In some cases, local beverage-alcohol industry groups print the risk cards and publicize the campaign. The national organization provides advice, materials for reproduction, and other technical assistance.

81P-1016
Pathways to Health.
Hopp, J. W.
Loma Linda University, School of Health, Department of Health Education, Loma Linda, CA 92350
Continuing.

Pathways to Health provides general health and nutrition information to elderly persons. Services include blood pressure screening and a series of health education classes

on cooking, physical fitness, stress management, cancer detection and prevention, arthritis, and self-care. Ninety-minute classes have met weekly for 6 years, with an average attendance of 75. Programs are conducted by candidates for master's degrees in health education and nutrition at the Loma Linda University School of Health. The effectiveness of the classroom interventions is assessed via oral and written tests administered at specified intervals.

81P-1017
Professional Health Resource Center, Inc.,
Granville, J. and Brin, D. 518 Avenue A, Box 6005, Rome, GA 30161
Funding Source: Appalachian Regional Commission, Washington, D.C.; Tennessee Valley Authority, Knoxville, Tenn.
November 1, 1979 - Continuing.

The Professional Health Resource Center, is a private, nonprofit health service agency that provides health promotion, health maintenance, and information services for rural residents in northwest Georgia. Based in Rome, Georgia, the center operates from 8 sites within a 70-mile radius and serves 400 clients each month. Staff members conduct health education programs on blood circulation, foot care, physical activity, nutrition, and other topics. Each presentation lasts roughly 40 minutes and includes time for questions and discussion. The presentations are given by consultants who represent numerous medical disciplines. Health education programs are conducted for county health departments, and the program operates a day-treatment mental health center and a diversion center for prisoners as an alternative to prison confinement. Screening programs are offered for high blood pressure; temperature, respiration, and pulse; height and weight; eye diseases; anemia; diabetes; and scoliosis. The center uses a mobile health education unit to provide some of its services. The center has recently increased its services to include grant proposal preparation and consultation on management, health services, health promotion, and health agency education. Though all residents of seven northwestern Georgia counties constitute the target audience, the center concentrates its attention on pregnant women and the elderly. Teaching consultants include nurses, podiatrists, nutritionists, and physicians.

81P-1018
U.S Air Force Health Education Program.
Piper. D. A.
Department of the Air Force, Air Force Medical Service Center, Consumer Health Education Division, Brooks AFB, TX 78235
July 1, 1977 - Continuing.

The U.S. Air Force Health Education Program was established to enable all persons connected with the Air Force to (1) assess their own health needs, (2) become involved in the health care process, (3) improve their quality of life, (4) reduce the personal and economic impact of illness by preventing disease, and (5) follow prescribed treatment regimens. Programming is developed and implemented by the health education coordinator at the Consumer Health Education Division (CHED), which will become part of each base's administrative structure. Each CHED functions as a resource center to provide materials, ideas, and encouragement for health education programming. In addition to aiding individual and community health education efforts, the CHED provides assistance to patient education programs and publishes and disseminates base-wide newsletters and related literature. All Air Force personnel and their families constitute the target audience, though each CHED confines itself to activities that are directed at base populations or subpopulations.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-1019
Changing Cafeteria Eating Habits.
Zifferblatt, S. M.; Wilbur, C. S.; and Pinsky, J. L.
Journal of the American Dietetic Association 76(1):15-20, January 1980.

The "Food for Thought" game, an 8-week media-based nutrition intervention program designed to influence food choices in a cafeteria setting, was conducted in the employee cafeteria at the National Institutes of Health, Bethesda, Maryland. Its purpose was to encourage customers to select a low-calorie, well-balanced meal. The "Food for Thought" game consisted of 52 cards with numbers and suits, each containing a specific nutritional message regarding either a particular food item or a nutritional or caloric comparison of alternative food choices. Employees received one card each day and were awarded prizes at the end of 4-, 6-, and 8-week periods based on matching pairs or collecting a full house. During the 8-week intervention period, skim milk purchases increased, and dessert and bread sales, as well as average number of calories purchased per day per person, declined significantly. To test for a maintenance effect, food selection rates and caloric purchases were observed for 10 weeks after the program ended. A time-series comparison of these data with results obtained during the interven-

tion period did not reveal a high degree of recidivism. Apparently, many customers were able to incorporate the changes in eating habits into a continuing, self-managed lunch program. The study results may have implications for successful delivery of other types of prevention programs. 22 references.

81P-1020
Johns-Manville Employee Education Program.
Hofmann, J. L.
Johns Manville Sales Corporation, Health, Safety and Environment Department, Ken-Caryl Ranch, Denver, CO 80217
Continuing.

The Johns-Manville Employee Education Program offers educational components designed to (1) reduce hazards to employees who work with asbestos, diatomite, fibrous glass, and polyvinyl chloride; (2) improve respiratory protection for employees; and (3) promote safety and accident prevention activities among employees. Educational materials include booklets and other literature, slide-tape presentations, films, posters, leaflets, and various other educational aids. In addition, personnel of the Health, Safety, and Environment Department are available for questions from employees. The department maintains a library of all medical research pertinent to Johns-Manville operations. Departmental staff can arrange presentations to internal and external groups on a variety of health and occupational safety topics, help local facilities determine toxicology hazards and precautions, arrange for special safety and accident prevention surveys of all Johns-Manville facilities, and arrange public education and community relations programs.

81P-1021
Lifestyle Seminars.
Stransky, F. W. and Arends, J.
Oakland University, Rochester, MI 48063
Continuing.

Oakland University, using the facilities of Meadow Brook Hall, a 100-room home owned by the university and used as a conference center, offers a lifestyle seminar program designed to help corporate employees understand and assess their present physical condition and set goals for improvement through a life plan based on weight control, nutrition, exercise, and stress management. Seminars include a complete physical examination, a stress test and confidential evaluation, lectures by qualified professionals, individualized exercise prescriptions, meals at Meadow Brook Hall, and use of exercise facilities at Oakland University. Though 1-day seminars are offered, a 3-day program is available, with accommodations for overnight stays. Facilities are also available at Meadow Brook Hall for tennis, golf, racquetball, handball, and indoor swimming. Fees vary with the number of services used.

81P-1022
National Chemsearch Fitness Program.
Stowers, J. J.
National Chemsearch, 2727 Chemsearch Boulevard, Irving, TX 75062
Continuing.

The National Chemsearch Fitness Program is a comprehensive fitness and recreational program designed to increase the activity level of National Chemsearch employees. The program provides aerobic exercise classes, an individualized jogging program, gymnasium facilities, cross-country jogging facilities, men's basketball programs, racquetball facilities, softball fields, tennis courts, volleyball courts, golf lessons, and biking and hiking programs. Competitive tournaments are sponsored by programmers, and the corporation employees receive a bimonthly newsletter on upcoming program events. In addition, the program has sponsored films on skin and uterine cancer, in response to a cancer survey taken by employees.

81P-1023
Western Wellness.
Blachowski, D.
Western Federal Savings, 200 University Boulevard, P.O. Box 5807 T.A., Denver, CO 80217
January 1980 - Continuing.

Western Wellness was designed to (1) encourage and help employees, their families, and community members to adopt healthier lifestyles; (2) provide low-cost lifestyle programming; and (3) promote better communication among Western Federal Savings employees. Services include classes and demonstrations concerning various wellness and self-care activities, a weight management self-help group, a wellness component incorporated into the company orientation program, operation of a small wellness library at each branch or office location, free juice distribution, and a quarterly speaker program. Classes and demonstrations include a 4- to 6-week stress management course; a 4-week rope-skipping class for fitness and aerobics; a cross-country skiing class; a yoga demonstration; a noon-hour runners clinic; noon-hour and after-work aerobic exercise, ski fitness, and belly dancing classes; a cardiopulmonary resuscitation training

program; and a Red Cross first aid course. Communication to wellness leaders at various company offices is achieved via weekly memos, monthly calendars, wellness bulletin boards, articles in the weekly company newspaper, a monthly newsletter, and monthly communication forms. Services are aimed at more than 700 employees working at more than 20 locations, their families, 100 other building tenants, and the community of Denver, Colorado. The program is administered by a central wellness committee, which consists of a wellness coordinator, a medical consultant, a personnel director, a public relations professional, a nurse practitioner, and five employee representatives. Data from employee questionnaires provide program evaluation.

81P-1024
Women's Occupational Health Resource Center.
Stellman, J. M.
Columbia University, School of Public Health, 60 Haven Avenue, B-1, New York, NY 10032
1977 - Continuing.

The Women's Occupational Health Resource Center (WOHRC) helps working women, trade unions, management, professionals, and government policy makers become aware of women's occupational health and safety needs and the necessity for adequate programs to deal with those needs. In addition to operating an extensive research library and information service, WOHRC facilitates communication among people and groups working in the field, provides technical assistance in establishing programs, operates a clearinghouse of materials produced by other organizations concerned with women's occupational health, and directs materials of its own to both lay and professional audiences. A computerized bibliographic information system enables WOHRC to run literature searches on single topics or combinations of topics. Workshops and training sessions are held at the center, and staff are available to speak at conferences and workshops. WOHRC also publishes a bimonthly newsletter, a quarterly technical bulletin, factsheets on specific occupational hazards, and selected bibliographies for specific occupations. Originally funded through a "New Directions" planning grant from the Occupational Safety and Health Administration, the center currently receives broad financial support from such organizations as the Ford Foundation, United Church Board of Homeland Ministries, United Automobile Workers of America, and Industrial Union Department of the AFL-CIO (American Federation of Labor-Congress of Industrial Organizations), and from many individuals.

HEALTH EDUCATION METHODOLOGY

81-1025
Inquiry Learning and Simulations.
Physician's Patient Education Newsletter 4(1):7-8, February 1981.

Inquiry-learning and simulation techniques are consistent with the philosophy of adult learning theory and of the self-care movement. Inquiry learning, also referred to as the "discovery approach" or "problem-solving approach," emphasizes the process of education over the content, relying on the Socratic question-and-answer method and providing resource persons for pupils' self-directed projects. In situations where therapy provides limited benefits but significant risks, an inquiry-learning approach to patient education may be appropriate. The provider should make textbooks and journals available, share medical records, and teach the patient decision-making skills. Simulations and games are structured approaches to inquiry learning. Examples of simulations are case studies, role playing, sociodrama, and computerized models. Areas with the greatest potential for simulation interventions include aging, venereal disease, human sexuality, consumer health careers, safety education, and health planning. Simulation has proven particularly useful in heightening patient-physician interaction, though this effect has occasionally become disruptive. 6 references.

81-1026
Selling Fitness Through "Health Promotion."
Barnes, L.
Physician and Sportsmedicine 8(4):119-123, April 1980.

The Sun Valley Executive Health Institute, a Minneapolis-based health promotion program, has introduced a long-weekend crash course in exercise, diet, health, and wellness. The program includes 3 days of intensive exercise and instruction, and 15 to 20 couples participate in each weekend program. The participants are usually middle aged with professional backgrounds. Thorough physiological testing of each participant precedes each program, and each participant receives individualized counseling from a nutritionist and an exercise physiologist. Small group discussions address stress management, sexuality, smoking cessation, and drug and alcohol use, and group relaxation sessions are part of the program. Approximately 45 percent of the 12,000 persons who have participated in the program during its first 6 years have been retested in followup procedures. Of those retested, 100 percent said that they had made lifestyle changes as a result of the program, 72 percent claimed to exercise at

least three times per week, 80 percent reported feeling better, and 54 percent reported a better psychological outlook. With the help of Health Central, a hospital administration organization with 115 affiliates, the program is taking on a nationwide scope. A program for nonprofessional persons has also been developed.

81-1027
New Concepts in Health Education.
Chesney, M.
Menlo Park, Calif., SRI International, 4 p., January 29, 1980.

When health education efforts depending on knowledge transfer or simple behavior modification techniques began to be perceived as ineffective, health educators began to broaden their methods to include self-efficacy techniques, to define the barriers impeding effective health behavior, and to develop scientific evaluation designs. The principle of self-efficacy says that the strength of people's beliefs in their own abilities to adopt new health behaviors affects the extent to which education will be successful. Thus, educators have emphasized the teaching of skills and the engendering of motivation and feelings of efficacy. Barriers targeted by educators have included those related to costs of health care, cultural differences, and access to care. Though evaluation techniques in health education are just being developed, the existence of complex multivariate designs, statistical procedures, and cost-effectiveness designs will enable educators to implement replicable evaluations of new techniques.

81-1028
Health Education Strategies for Influencing Health Planning and the Health Policy Process.
Dawson, L. and Steckler, A.
Paper presented at the Annual Meeting of the American Public Health Association, Washington, D.C., November 1977, 6 p., November 1977.
Available from: NTIS; Order No. HRP-0028720.

Researchers at the Department of Health Education of the University of North Carolina School of Public Health formulated a plan to influence health policy in a North Carolina health systems agency. In conceptualizing the policy process with reference to Public Law 93-641, the researchers distinguished three components of health policy: (1) policy formulation, (2) policy content, and (3) policy administration. They further identified areas of particular relevance to health education for each of the components. Subsequent to conceptual analysis and issue identification, intervention strategies were selected, including training board members, staff, and health educators; monitoring and influencing board and committee selection processes; organizing local health educators; and establishing a public involvement committee within the board and agency. These strategies have had a desirable effect upon the qualitative and quantitative objectives identified for each policy component. During the past 2 years, each strategy has been implemented with varying degrees of success.

81-1029
A Demonstration of the Use of Graphics in Teaching Children Nutrition.
Feshbach, N. D.; Jordan, T.; Dillman, A.; and Choate, R.
Journal of Nutrition Education 10(3):124-126, July-September 1978.

A series of pilot studies were conducted by the Council on Children, Media, and Merchandising (CCMM) to explore the effectiveness of using graphics to teach young children about nutrition. A robot figure called the "nutrition computer" was developed as the graphic model to teach 88 children, 4 to 10 years old. Three treatment conditions were used to compare the effectiveness of the graphic model with a numeric method of transmitting the nutrition information. Age and grade levels for each condition were selected to identify the minimum age and grade for comprehension of the materials and concepts under each condition. The results showed that the study subjects were able to understand and use graphic information to make judgments about food, both immediately after an orientation session and a week later. Although the younger children were less accurate in reporting information, all of the children were able to comprehend the complex relationship of calories and nutrients and to evaluate foods. Study findings suggest the desirability of supporting programs to teach children how to interpret and utilize the nutrition computer or similar graphic portrayals. Such programs could include public service announcements, childrens' television shows, and curricula in the schools. The study findings also indicate that children can be taught how to evaluate advertisements for food and other products that appear on television.

81-1030
An Interpersonal-Effectiveness Approach to Consumer Health Education: Rationale and Case Study.
Ford, J. D.
Medical Care 17(10):1061-1067, October 1979.

To determine the efficacy of teaching medical care consumers interpersonal-effectiveness advocacy skills, par-

ents of developmentally disabled children attended one of two 6-hour workshops to learn self-management, communication, and social influence skills for dealing with health consultants. The workshop format was derived from the assertiveness training approach. After a program overview, specific skills were explicitly defined, demonstrated, and briefly rehearsed by participants during the morning sessions. In the afternoon, participants formed small groups and rehearsed interpersonal-effectiveness skills through role-playing with a doctor, a teacher and a principal, and a lawyer. The workshops concluded with a brief review, and participants completed behavioral contracts specifying when and how they would apply the new skills in their next interaction with a health consultant. Self-reported reactions to the program, collected on an anonymous basis immediately after the workshop sessions, suggested a high level of participant satisfaction. Directions for future research and development are examined. 28 references.

81-1031
The Education Role of the Nurse Practitioner.
Gibbs, J.
Australian Nurses' Journal (Melbourne) 10(1):37-39, July 1980.

To fulfill their educational roles, nurse practitioners must have certain personal and professional qualities and understand the learning process as well as teaching methods and techniques. Personal and professional prerequisites include (1) the ability to conceptualize a framework to guide thought and action, (2) a positive and realistic acceptance of the self, (3) an inner security in dealing with high-risk situations, (4) a nondogmatic attitude toward the educational role, (5) an ability to minimize threats to others and involve learners in self-initiated learning and evaluation, and (6) an ability to act as an effective role model. Nurses can enhance these abilities through reading journals, using library services, attending seminars and courses, and being involved in professional activities. Learning principles that the nurse must know and apply include (1) the different levels of psychomotor, cognitive, and affective skills possessed by various patients; (2) the social nature of education; (3) the need to make the learning experience significant to the learner; (4) the need for motivating and involving the learner actively in the learning process; and (5) the need to create a positive self-concept in the learner. The nurse should be aware of available audiovisual and written aids and inservice training programs available to enhance the teaching role. 12 references.

81-1032
Health Information and Health Education: There's a Big Difference Between Them.
Green, L. W.
Bulletin of the American Society for Information Science 4(4):15-16, April 1978.

To prevent confusion between health information and health education, health educators should be aware of fallacies concerning health information, information policy issues, and available health information resources. Fallacies held by many health educators include the identification of information provision with information utilization, belief that any information is better than none, belief that more information is necessarily better than less, identification of exposure to information with impact, and belief that some standardized message can be developed for all target audiences. In the area of information policy, health educators must clarify the goals and priorities for health education, develop the knowledge for achieving these goals and addressing these priorities, and learn about available resources for accomplishing specified goals and priorities. The four types of resources available to health education include manpower, the media, the health education process, and various coordinating mechanisms.

81-1033
Strategies for Promoting Nutrition and Dietitians.
Henneman, A. and Vickstrom, J.
Journal of the American Dietetic Association 77(4):466-468, October 1980.

As part of a National Nutrition Month outreach effort to promote nutrition and dietitians, the Nebraska Dietetic Association approached various professional associations in the State about featuring articles on nutrition in their newsletters. Topics were selected in cooperation with the associations, and dietitians were matched with topics. Direct contact between the dietitian-writers and the respective associations was encouraged in order to further professional exchanges. The Association's public relations strategy permitted greater dissemination of nutrition information to specific target groups through existing channels of communication. Major concerns addressed in developing the project were (1) the lack of recognition for dietitians as qualified sources of nutrition information; (2) the tendency of dietitians to exchange information only among themselves; (3) the lack of attention to the needs of specific target populations; and (4) financial constraints that permit only a limited amount of public relations work by dietary associations. A list of the participating organizations and descriptions of the featured nutrition articles are provided. 2 references.

81-1034
Bibliography on Health Policy and Lifestyle Behavior Change.
Huber, M. J.
Monticello, Ill., Vance Bibliographies (Public Administration Series: Bibliography P-161), 28 p., January 1979.

Annotated citations are offered of literature on health policy directed at lifestyle change. Categories include philosophy, goals, social and psychological factors, arrangement of the environment to facilitate change, practical values, and strategies deserving further investigation.

81-1035
Supervised Toothbrush Instruction for Pre-School Children.
Livingston, J. F. and Muirden, D. M.
Australian Nurses' Journal (Melbourne) 9(8):44-46, March 1980.

A combination approach to dental hygiene instruction for health workers and nursing specialists dealing with preschool children is presented. The approach is based on (1) plaque detection during toothbrushing instruction and supervision; (2) plaque removal at home; (3) parental involvement through attending an initial hygiene demonstration and reporting on home progress; (4) the use of a systematic toothbrushing technique on a large model of the mouth and instruction on the use of disclosing tablets; and (5) instructional reinforcement through leaflet distribution, demonstration with models, and periodic performance tests. Specific points of advice are discussed. 4 references.

81-1036
Patient-Health Information--The Librarian's Role: One Perspective on How Public Libraries Can Assist in Delivering Health Information to the Public.
Maas, N. L.
In: Patient-Health Education: The Librarian's Role. Proceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 38-40, 1979.

The nationwide network of public libraries should facilitate access to health information by functioning as community information centers. To perform this function public libraries will need to clarify their goals, objectives, and procedures, and prepare their staffs to function as information and referral agents. Libraries can build their image as information centers through (1) administrative commitment, (2) continuous staff training; (3) mechanisms to ensure that information and referral roles are being fulfilled; (4) well-planned community advertising campaigns; and (5) adequate staff resources devoted to community information dissemination. The Detroit Public Library and its 26 branches use traditional library skills to direct people to information and essential human services through a referral service called TIP (The Information Place). Active assistance, followup, and satisfaction of individual requests are integral to the library service. Responses by the public and by human service providers have been excellent. TIP is also searching for appropriate information on health and other critical areas in order to prepare pamphlets for dissemination in all libraries.

81-1037
Group Discussion and Drug Abuse Prevention.
Madsen, D. B.
International Journal of the Addictions 14(8):1117-1123, 1979.

A study involving 105 women randomly selected and recruited from introductory psychology classes at the University of Michigan was designed to assess the efficacy of a technique known as the "choice shift procedure." The procedure entails requesting leaderless groups of peers to discuss issues freely with the goal of reaching a consensus. The women were assigned to groups of four or five in which either the group choice shift or individual argument procedure was used. Women in the individual argument procedure wrote arguments for three issues pertaining to drug use, while women in the choice shift procedure discussed three issues with the goal of arriving at a consensus. Discussions were to last 7 minutes per issue, and discussion topics included use of various drugs to create specified effects. Immediately before and after the sessions, participants were asked to indicate their personal choices regarding drug use, and 3 months later all participants were asked to respond to a drug attitude scale. Analysis of the personal choice statements and attitude scale data indicated that the group choice shift procedure provided both immediate and long-term reinforcement of antiabusive drug attitudes and that use of leaderless groups enhanced the credibility of the group experience. The procedure is inexpensive to apply and has demonstrated its effectiveness in changing behavior as well as attitudes in another study. 9 references.

81-1038
The Case for a Problem Prevention Approach to Alchohol, Drug, and Mental Problems.
Room, R.
Public Health Reports 96(1):26-33, January-February 1981.

Though specific disease prevention strategies are being compared to broader health promotion campaigns, particularly those for alcohol and drug abuse control and mental health, it may be more helpful to view the two approaches as working independently rather than competitively. The rhetoric of health promotion is compatible with contemporary thinking and programs for alcohol, drug, and mental problems. Moving away from the scare tactics of traditional drug and alcohol education, preventive efforts are presently promoting alternative lifestyles and activities, affective education, and values clarification. Though the rhetorical distinction between health promotion and disease prevention is similar to the long-standing split in the mental health-mental illness field, emphasis by clinicians on primary prevention of psychopathology and the vagueness and political nature of the goals of mental health promotion have hindered promotional efforts in this area. Children have become the central target of mental health prevention efforts. A broader definition of prevention and a wider scope for preventive efforts in the fields of alcohol and drug abuse control and mental health are necessary. 22 references.

81-1039
Drug Abuse Films.
Sackett, R. W.
Rockville, Md., National Institute on Drug Abuse, (DHEW Publication No. (ADM) 80-914), 26 p., 1980.

An alphabetical listing of privately and federally produced films on drug abuse is presented. Each entry includes the year of production, the distributor's name and address, running time, sale price, intended audiences, and a brief synopsis. All films are 16mm sound productions. An audience and a topical index are appended.

81-1040
Getting the Word Out.
Tans, M. D., ed.
Madison, Wis., Wisconsin Clearinghouse for Alcohol and Other Drug Information, Board of Regents of the University of Wisconsin System, 74 p., 1979

Guidelines are provided for developing public awareness campaigns for agencies and organizations involved in alcohol and drug abuse prevention and education. Topics include evaluation of available resources; development of a plan; means of reaching the public; selection of a delivery channel; evaluation of a public awareness activity; principles of communication; means of reaching hard-to-reach groups, poor urban communities, and people in rural areas; means of changing attitudes; and use of radio, television, newsletters, newspapers, brochures, slide-tape shows, billboards, bus cards, posters, exhibits, and speakers bureaus. Numerous references.

81-1041
Health Education: A Consumer Imperative.
Turner, P. A.
In: Patient-Health Education: The Librarian's Role. Proceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 21-27, 1979.

Librarians can be an important link in providing health care consumers with the knowledge for informed decision making. A number of inquiries that reach librarians are related to interpretations and implications of specific diagnoses or the type and appropriateness of a specific treatment. Inquiries are frequently related to symptoms only, for many people seek information prior to seeking medical diagnosis and care. Others seek confirmation of information already received as one method of obtaining a second opinion. A brief review of health care delivery systems and health education shows that there is a long tradition of self-help health care parallel to the professional medical care delivery system. Health care consumers are increasingly seeking information from sources other than physicians. Nonphysician health care providers are taking risks in providing information to patients regarding choices and alternatives in treatment, but it is a greater risk to withhold information related to health care decisions. 1 reference.

81-1042
A Catalog of Free Loan or Low Cost Audio Visual Aids for Health Education.
Tuskegee Area Health Education Center, Inc., Tuskegee, Ala.
Atlanta, Ga., Center for Health Promotion and Education (DHHS, CDC), 24 p., (197-).

Annotated citations of inexpensive or free audiovisual aids for health education are provided. The sources cited cover aging, alcohol use and abuse, arthritis, blood pressure and hypertension, cancer, child growth and development, community health, courtship and marriage, dental health, diabetes, environmental health, epilepsy, family planning, eye and ear health, heart health, hospitals and nursing homes, the human body, kidney disease, mental retardation, narcotics, nutrition, obstetrics and gynecology, Pap smears, diseases affecting the rectum and colon, rehabilitation, sickle cell anemia, smoking, tuberculosis, and venereal diseases. A list of sources is appended.

81-1043
Health Information Resource Centers: A Community Necessity.
Williams, J. F., II
In: Patient-Health Education: The Librarian's Role. Proceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 93-96, 1979.

Public library health information resource centers are ideal organizations to coordinate the efforts of agencies, health groups, and volunteers in community health education. Short-term objectives of the resource centers include identification of community agencies with health education programs and cooperation with them in the collection, retrieval, dissemination, and evaluation of information on local health education (1) personnel; (2) programs and activities in the private, public, and voluntary sectors; and (3) materials and information on the use of various health care systems. The long-term objectives of the resource centers include the development of communication between existing health education programs and the resources and services of their local counterparts. Since the ultimate goal of the resource centers is relating the work of one community agency to another for the public good, their source of fiscal support should not differ from that of the public libraries. 2 references.

PATIENT EDUCATION

81-1044
Pre-Op Visit Calms Fears.
Arnold, R.
Hospital Administration in Canada (Don Mills) 20(4):28-30, April 1978.

Pre- and postoperative visiting by operating room nurses can help calm patients, because it puts them into contact with a familiar person with whom they can converse; it also helps reduce the nurses' isolation from the rest of the hospital. In preparing nursing histories, nursing diagnoses, and nursing care plans, the operating room nurse can benefit greatly from exchanges with the patient. During the preoperative visit, the nurse's chief reponsibility regarding the patient is to deal with anxiety about surgery. Determining the patient's understanding of the surgical procedure can facilitate surgical scheduling. Nursing assessment of the patient's psychological condition and knowledge of the procedure should be included on the patient's chart for review prior to the operation.

81-1045
A Comparison of In-Hospital Education Approaches for Coronary Bypass Patients.
Barbarowicz, P.; Nelson, M.; DeBusk, R. F.; and Haskell, W. L.
Heart and Lung 9(1):127-133, January-February 1980.

Two educational methods related to coronary artery disease and its treatment were compared in 3 hospitals by using 230 patients undergoing uncomplicated coronary artery bypass grafting. Patients were randomly assigned to receive either slide-sound education or the usual education offered in each hospital. Knowledge, anxiety, and health-related behaviors were evaluated by interview or questionnaire before teaching, at discharge, and 1 and 3 months after discharge. Increases in knowledge scores during the hospital stay were significant in both teaching groups, but were more than twice as great in the slide-sound group. After discharge, the slide-sound group scores remained significantly higher for 3 months. Anxiety decreased significantly and health-enhancing behaviors increased significantly in both groups, without differences between groups. The superiority of slide-sound teaching programs suggests a need for reappraisal of current education practices for coronary bypass patients. 15 references.

81-1046
A Coordinated Patient Education Program in a Community Hospital.
Birk, R. E.
Journal--Association for Hospital Medical Education No. 1:23-25, 1977.

In 1976, St. John Hospital in Detroit, Michigan, established the Patient Education Center, which also offers an inservice nursing education component. Facilities included a medical library, an auditorium, classrooms for all hospital education programs, and a sound proof videotape production studio. Program components were modeled after the closed-circuit videotape program for obstetrical patients at Barnes Hospital in St. Louis, Missouri, the health education library at Kaiser Permanente Hospital in Oakland, California, and an audiovisual series developed by Core Communications in Health in New York. The four major program components are (1) a community health program involving videotape and classroom components, (2) a library with books and pamphlets, (3) a videotape program that provides tapes to patients at their bedsides, and (4) the Core Communications in Health's audiovisual series through which physicians prescribe tapes to in- and outpatients on 58 health-related topics. The patient's educational needs are assessed upon entry into the Center and at various times throughout

individual educational programming. Patients are charged a small fee. The program has been accepted by both patients and physicians. 3 references.

81-1047
Teaching Activities of Family Nurse Practitioners.
Draye, M. A. and Pesznecker, B.
Nurse Practitioner 5(5):28-29, 32-33, September-October 1980.

To document specific nurse practitioner teaching activities, a nationwide study was conducted to quantify and describe the teaching activities of 356 family nurse practitioners (FNP's) in the course of acute, chronic, and wellness care, and to determine the influence of educational preparation and practice setting on teaching activities. The study documented patient problems and nursing services by monitoring patient logs over a 2-day period. A nursing activity code sheet, consisting of 52 items organized according to the major categories of assessment, intervention, and disposition, was attached to each patient log. Results show that teaching accounted for nearly half of all interventions, and was directed at informing patients about their diagnosis and care plan. The remaining teaching focused on prevention and child care. A third of the patients received instruction about preventive health practices. Results indicate that FNP's focus preventive teaching at all age groups with a slight emphasis on children. For preventive teaching to be done effectively, three criteria are necessary in the practice setting: time, resources, and a systematic approach to patient education. Comprehensive preventive teaching may be enhanced by group sessions, use of audiovisual materials, home teaching, and interdisciplinary teams and additional community nursing resources to supplement and followup on patient teaching. Routine implementation of preventive health teaching geared to specific risk factors associated with particular age groups or lifestyle practices is advocated. 7 references.

81-1048
Lamaze Childbirth Training and Changes in Belief About Personal Control.
Felton, G. S. and Segelman, F. B.
Birth and the Family Journal 5(3):141-150, Fall 1978.

A study involving 59 men and 72 women, divided into 3 groups, was designed to measure the degree to which beliefs about the origin of control for behavior and its consequences might change on the part of people who complete Lamaze childbirth training classes. The first group was divided among six different Lamaze classes, the second group was divided among four different American National Red Cross Preparation for Parenthood classes, and the third group underwent no formal training. Beliefs were assessed by means of the 29-item Rotter Internal-External Scale, which is designed to determine the degree to which people believe the origin of control of behavior to be internal or external to themselves. The scale was administered before and after the classes for those taking classes and at the beginning and end of a 3- to 6-week period for the controls. Data analysis indicated that Lamaze training for women led to a significant increase in new mothers seeing themselves as origins of control. Other modes showed no significant change for women. No significant postpartum findings emerged for men under any conditions. The findings provide a better understanding of the attitudes that expectant parents have prior to delivery, and will aid in the design of more effective Lamaze training sequences and elements of teaching and counseling. 10 references.

81-1049
Making Hospital Preparation Child-Centered (With a Little Help From Emily).
Ferguson, F. and Robertson, J.
Journal of the Association for the Care of Children in Hospitals 8(2):27-31, Fall 1979.

The Alberta Children's Hospital has initiated the Preadmission Visiting Program, a child-centered hospital preparation program that draws on the coordinated efforts of the recreation and child life department and the nursing department. The recreation and child life department developed a coloring book featuring a cat named Emily, a central character with whom the children can identify. Emily conveys information and entertains the children. The coloring book became part of the nursing department's home visitation program. During a typical visit, the nurse and the mother complete admission forms, consent forms, and a nursing pediatric history sheet, and the nurse explains to the mother various procedures that the child will undergo. Next the nurse goes through the coloring book with the child. On admission day, the same nurse meets the mother and child, guides them on a tour of hospital facilities, and brings the child to a playroom featuring a puppet show, with the coloring book character as the central puppet, and a hospital game that allows the children to familiarize themselves with hospital equipment. These program components ensure that the child has a positive attitude toward the hospital and the healing process. 9 references.

81-1050
How Effective Is Patient Education?
Geyman, J. P.
Journal of Family Practice 10(6):973-974, June 1980.

More research is needed on patient education methods to test their capacity to improve patient outcomes. Studies conducted during the past 10 years on the effectiveness of patient education in family practice have produced different results; some studies have demonstrated improved compliance and outcomes as a result of patient education, but many others have failed to document beneficial results. One such study is an analysis of the effectiveness of patient education and psychosocial counseling in promoting compliance and control among hypertensive patients. Results showed no significant improvement in either compliance or blood pressure control compared with family physician visits alone. Research to date points to three basic causes of ineffective communication between physicians and patients: (1) physicians' failures to provide a consultation perceived by patients as satisfying; (2) patients' failures to understand what they are told; and (3) patients' failures to remember what they are told. Empirical studies in each of these areas suggest positive approaches to more effective patient education. Suggestions are offered for improving communication between physician and patient, and for improving the patients' memory and understanding. 11 references.

81-1051
Circumcision and Patient Education (Letter).
Gorske, A. L.
American Journal of Diseases of Children 134(5):527, May 1980.

To facilitate counseling of parents about circumcision, the Department of Pediatrics at the Naval Regional Medical Center in Great Lakes, Illinois, prepared a handout on newborn circumcision. The leaflet presents both advantages and disadvantages of the procedure. Parents are asked to sign a statement indicating that they have read the leaflet and are counseled by the attending physician. The use of printed educational materials has resulted in a marked reduction in physician time required to ensure informed consent and has also been associated with a 30 percent reduction in the neonatal circumcision rate. 2 references.

81-1052
Self-Medication: A Developing Concept in Future Hospital Pharmacy Service.
Hannay, D. G.
Hospital Administration Canada (Don Mills) 19(1):33, 36-37, January 1977.

A self-medication program promoted by the director of pharmaceutical services at the Victoria Hospital in London, Ontario, was implemented in the 12-bed rehabilitation ward. After completion of a week-long assessment period, involving the entire rehabilitation team, each patient received a printed introduction to the program, instruction from a pharmacist on self-medication, and a supply of drugs with informative labels. Drug supplies were replenished regularly, and the pharmacist kept careful records for each patient to determine compliance levels. During a 22-month study of the program, 119 patients were discharged from the ward; 50 of the patients were deemed suitable for program participation. Participants ranged from 13 to 70 years old. A survey of 13 patients during a 4-month study indicated that (1) the adherence level to the drug regimen of an average patient was 83 percent; (2) self-medication patients consistently used less laxative, analgesic, and hypnotic medication than permitted; (3) spouses of self-medication patients frequently became involved in compliance behavior; and (4) patients who needed assistance in taking drugs became self-sufficient during the program. Though the program suffered from the exclusion of the pharmacist from the patient selection process, it did demonstrate the value of self-reliance programs in decreasing institutional dependency.

81-1053
Nutrition Broadcasting.
Hyland, K. M.
Journal of Human Nutrition (London) 34(1):52-53, February 1980.

Dietitians at the Whittington Hospital in London, England, have developed and implemented a 12-week series of hospital-based radio programs on human nutrition. The series is broadcast to 2,000 patients and staff of hospitals within 12 square miles. Before each series, 12-page booklets containing details of broadcast dates, program titles, speakers, and script summaries are compiled and distributed, and guest speakers receive an outline of the show's interview, usually a discussion of three questions or topics with the dietitian. Broadcasts are transmitted after the morning coffee break, which is the peak listening time. The programs have brought national acclaim to the dietitians, an increased interest and knowledge of nutrition among the hospital staff, an increased workload in the dietetic department, and an increase in the local consumption of whole-grain bread. 12 references.

81-1054
Patient-Health Education: The Hospital Librarian's Role.
Johnson, B. C.
In: Patient-Health Education: The Librarian's Role. Pro-

ceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 8-15, 1979.

The hospital librarian's role in patient education has been largely overlooked, with hospital library services designed primarily to meet the information needs of medical practitioners and to provide recreational reading material for patients. Barriers to the hospital librarian providing patient education materials include (1) lack of training for direct patient care and (2) fear of overstepping ethical boundaries in patient-professional relationships. Librarians also realize that technical information may be misunderstood and may produce anxiety when presented to patients without the perspective established by a health care professional, and the librarians are uncertain about their competency to choose authoritative materials for lay people. Important roles for the librarian include (1) gathering information relevant to an individual patient's illness; (2) disseminating it to patient education personnel; (3) storing, classifying, and organizing educational materials directed toward the specific needs and requests of patients and their families; (4) collecting materials written or produced for the public by recognized authorities; and (5) promoting with public medical materials the kind of bibliographic and quality control found in information designed for health professionals. Links should also be established between librarians in health institutions and those in public libraries. 21 references.

81-1055
Knowledge of Diabetes Mellitus, Diets and Nutrition in Diabetic Patients.
Karlander, S. G.; Alinder, I.; and Hellstrom, K.
Acta Medica Scandinavica (Stockholm) 207(6):483-488, 1980.

A study of outpatient diabetics treated in a Stockholm hospital explored levels of knowledge concerning diabetes, diet, and nutrition. A multiple choice questionnaire was administered to 317 diabetic patients, 70 nondiabetic patients, 53 nurses, and 42 third-year medical students. Study results showed a correlation between test scores in diet-nutrition and some variables of diabetic control. There were more correct answers to questions about diabetes than to questions about diet-nutrition. A test score of 80 percent on the diet-nutrition section was considered necessary for proper management of the diet at home. This level was reached by 84 percent of the medical students, 26 percent of the nursing personnel, 29 percent of the insulin-treated diabetics, 9 percent of the tablet-treated diabetics, and 4 percent of the nondiabetic patients. Diabetic patients who participated actively in their daily self-care achieved better scores in diet-nutrition than the others. Among insulin-dependent patients, significant inverse correlations were found between test scores and body weight and blood glucose and serum triglyceride concentrations. Results suggest that the piecemeal instructional system used to teach diabetic patients in this hospital is inefficient and should be replaced by a formal educational program integrated into the patient care system. The level of knowledge among nursing personnel also needs to be improved. American studies on education of diabetic patients also conclude that the level of knowledge is too low to permit effective self-management. Results of the new formal educational program now underway at the Stockholm hospital will be reported in future publications. 12 references.

81-1056
Compliance With Medical Regimens During Adolescence.
Litt, I. F. and Cuskey, W. R.
Pediatric Clinics of North America 27(1):3-15, February 1980.

The determinants of adolescent medical noncompliance were investigated to gain insight into the development of adolescent health behavior. Topics include direct and indirect compliance measurements, including analysis of body fluids, pill counts, self-reports, outcome assessment, and physician estimate of compliance; the extent of noncompliance; noncompliance patterns; noncompliance determinants, including patient, family, therapy, illness, the physician-patient relationship, and medical care setting characteristics; and improvement of compliance behavior through educational strategies, medication packaging, patient supervision, behavior modification, and the patient-physician relationship. The first step in increasing compliance involves systematic compliance monitoring, rather than monitoring only when noncompliance is clinically suspected. When compliance is a problem, a more positive outcome may be achieved by determining circumstances that have fostered successful compliance and attempting to individualize the regimen accordingly. Barriers such as side effects, previous negative experiences with the medicine, and lack of conviction about the diagnosis or appropriateness of therapy should be explored. 54 references.

81-1057
Education of Independent Elderly in the Responsible Use of Prescription Medications.
Lundin, D. V.; Eros, P. A.; Melloh, J.; and Sands, J. E.
Drug Intelligence and Clinical Pharmacy 14(5):335-342, May 1980.

A pilot study tested the effectiveness of medication instruction by using 61 volunteers, 65 years old and above. The subjects were interviewed regarding their medication-taking practices and individually instructed via oral techniques, written techniques, oral and written techniques, or oral and written techniques reinforced by memory aids. The overall preinstruction compliance level for the subjects was 98.8 percent. Postinstruction interviews revealed no significant differences in compliance across groups. Yet, although compliance, judged specifically on the basis of the prescription label instructions, was extremely high both before and after instruction, drug-taking behavior and knowledge did change as a result of the interventions. The preinstruction compliance score did not necessarily reflect safe or desirable drug-taking behavior. No specific information was given to clients concerning their prescriptions and prescription medications, an omission that represents a much broader problem than noncompliance. 47 references.

81-1058

Dietary Recommendations for Individuals With Diabetes Mellitus, 1979: Summary of Report From the Food and Nutrition Committee of the American Diabetes Association.

Nuttall, F. Q.

American Journal of Clinical Nutrition 33(6):1311-1312, June 1980.

In 1979 the Committee on Food and Nutrition of the American Diabetes Association published a guide for health professionals who deal with the nutritional needs of diabetics. The guide emphasizes that (1) a nutritionally adequate, mixed diet is satisfactory for most diabetics; (2) dietary recommendations should be flexible; (3) education of diabetics and their families is the key for developing a reasonable treatment regimen and for maintaining patient compliance; (4) diet and meal planning should be highly individualized; and (5) the best treatment for obese, insulin-dependent diabetics is weight loss and maintenance of a desirable body weight. In addition to these principles, the diet should contain 12-20 percent protein, 50-60 percent carbohydrates, and up to 10 percent polyunsaturated fats. A modest restriction in salt intake should be considered, alcoholic beverages may be used in moderate amounts, and nutritionally incomplete fad diets should be avoided. No Committee positions were taken on the use of dietary fiber or the use of sorbitol and fructose as sweeteners. 5 references.

81-1059

Baseline Assessment of Patient Education in Clinical Practice.

Ory, M. G.; Buckingham, J. L.; and Windsor, R. A.

Physician's Patient Education Newsletter 4(1):3-4, February 1981.

A study in a clinical practice setting was designed to observe the health education content of physician-patient encounters, as part of a 3-year grant awarded to the Department of Family Practice at the University of Alabama at Birmingham by the Bureau of Health Manpower. A review of existing patient education studies in primary care settings resulted in a list of 24 components important to patient care and management. These components were related to communication, educational-behavioral diagnosis, the treatment plan, and utilization of specific patient education materials. Criteria for recording the degree to which observed physician-patient interaction integrated these components were incorporated into standardized recording forms. The forms were used to assess videotapes of 50 physician-patient encounters. Over 90 percent of the encounters were characterized by good communication on the part of the physicians. Components conducive to good behavioral diagnosis were less evident, though physicians' treatment plans were likely to include the more important components. The videotapes revealed a lack of traditional activities such as providing educational materials, utilizing multimedia resources, or referring the patient for further education. Areas in which weaknesses were found should receive more attention during medical training.

81-1060

Programmed Instruction as a Patient Teaching Tool: A Study of Myocardial Infarction Patients Receiving Warfarin.

Rankin, M. A.

Heart and Lung 8(3):511-516, May-June 1979.

A study was conducted of 19 patients recovering from myocardial infarctions in an Iowa hospital to compare two methods of teaching patients about their anticoagulant medication and to measure learning and retention levels. The main hypothesis tested was that programmed instruction using the booklet "Programmed Instruction for Patients Maintained on Warfarin Therapy" would be more effective in patient teaching than routine teaching practices following the American Heart Association's leaflet, "Anticoagulants, Your Physician and You." Patients were given two quizzes, one a few days after completion of programmed instruction or routine teaching to measure learning, and one 3 weeks later to measure retention.

Study findings validate the hypothesis that programmed instruction is more effective in promoting both learning and retention than routine teaching practices. Programmed instruction has the advantage of ensuring standardized teaching content, and the self-paced, individualized learning approach is not contingent upon the time nurses are available to teach. Several limiting factors of the study are discussed, which might be controlled or investigated in further research. 14 references.

81-1061
Patient Information and Patient Preparation in Orthognathic Surgery: A Medical Audit Study.
Rittersma, J.; Casparie, A. F.; and Reerink, E.
Journal of Maxillofacial Surgery (Stuttgart) 8(3):206-209, August 1980.

A study involving 110 patients who had undergone various kinds of orthognathic surgery to correct facial deformities assessed the levels of patient satisfaction with the results of the procedures. Responding by means of a written questionnaire, 94 percent of the patients expressed satisfaction with the preparation and final outcome of the surgical procedure. Twenty to forty percent of the patients, however, indicated that they were not properly informed about postoperative complications. On the basis of the deficiencies indicated in the questionnaires, appropriate patient education information was assembled. There are plans to measure the effectiveness of this material. 23 references.

81-1062
Social Support and Patient Education.
Shinn, M.; Caplan, R. D.; Robinson, E. A. R.; and French, J. R. P., Jr.
Urban Health 6(4):20-21, 57-59, June 1977.

In a recent study by the Michigan Institute for Social Research and the Henry Ford Hospital, 200 patients with diagnosed hypertension participated in a program designed to assess the differential effects of social support and lecture interventions. Patients in the lecture program attended four 60-minute presentations by nurses on the effects of high blood pressure, the role of stress, medications used in the treatment of hypertension, and dietary restrictions. The presentations included guest lectures by a pharmacist and a dietitian, films, and question-and-answer periods. Patients assigned to the social support intervention met with nurses for six 2-hour sessions, which covered the information provided in the lectures and also included discussions and role playing. A psychologist, pharmacist, and dietitian attended some of the social support sessions, and several exercises on question-asking skills were incorporated into the sessions to improve group dynamics. A control group received neither intervention. Preprogram questionnaires assessing knowledge, anxiety, somatic complaints, and social support were administered to all patients, and 77 patients were posttested over a 6- to 8-week period. Results showed that (1) social support patients were most likely to have clinically controlled blood pressure; (2) the traditional lecture approach was almost as effective as the social support approach; and (3) complex therapeutic regimens led to low compliance levels. 11 references.

81-1063
Learning as a Life Experience: The Case of the Cardiac Patient.
Storlie, F.
Supervisor Nurse 8(7):61-62, 65-67, 69, July 1977.

Nurses who are health educators must understand the principles of teaching if they are to deal effectively with cardiac patients affected by high-risk lifestyle habits. The nurse should understand the principles related to biofeedback, progressive relaxation, operant conditioning or behavior modification, cognitive field theory, and discovery-learning methods. In determining instructional principles, the nurse should specify experiences that will influence the patient significantly, specify the ways in which a body of knowledge should be structured, plan an effective sequence for presentation of the materials to be learned, and specify the intrinsic rewards of learning. To ensure proper respect for the individuality of the patient, the nurse should (1) establish a goal of mutual understanding and acceptance and (2) develop a mutual responsibility for the patient's educational and health care regimen. The nurse must be able to recognize and assess changes in knowledge, skills, attitudes, and behavior. 11 references.

81-1064
How Misconceptions Deter Maintenance.
Ward, G. W.
Urban Health 6(4):28-29, June 1977.

Indications that 10 million Americans are aware that they have hypertension but are unwilling to comply with the necessary therapy suggest the need for serious health education and promotion efforts, particularly during the crucial early months of therapy. Studies reveal that the primary factors affecting patient compliance among hypertensives are the patients' interactions with their families and with medical personnel. Misconceptions that

interfere with the complex decisions hypertensive patients must make include beliefs that (1) normalizing hypertensive conditions is equivalent to curing that condition; (2) high blood pressure is the result of nervous tension; (3) hypertension is always accompanied by symptoms; and (4) certain lifestyle changes can be substituted for medication. In addition to informing patients of the nature and treatment of their disease, physicians should prepare patients for the short-term side effects of medication and involve family members in therapy. A systematic educational and motivational process should be offered in simple language and supplemented by the use of leading questions, educational checklists, and periodic reviews. 3 references.

81-1065
Effectiveness of Patient Education and Psychosocial Counseling in Promoting Compliance and Control Among Hypertensive Patients.
Webb, P. A.
Journal of Family Practice 10(6):1047-1055, June 1980.

A study of 123 low-income, rural, black hypertensive patients was conducted to assess the effectiveness of two intervention strategies--group patient education and individualized psychosocial counseling--in relation to knowledge, anxiety, and locus of control. The group was pretested at a family practice clinic in Florida, on several psychological characteristics and randomly assigned to one of three groups: patient education and family physician appointments; psychosocial counseling and family physician appointments; or family physician appointments only (the base-line medical care, which served as the control condition). After intervention and followup lasting 3 months, compliance was measured in terms of keeping appointments, bringing hypertension medications to each appointment, using these medications regularly, and lowering diastolic blood pressure. Results indicated that neither patient education nor additional psychosocial counseling improved compliance or blood pressure control more significantly than did regular family physician visits alone. This does not mean, however, that physicians should not educate newly diagnosed patients or refer them for counseling if necessary. The key to improved compliance may be whether the followup medical care is sufficiently individualized to (1) assess specific problems and help patients resolve difficulties with their particular regimens, (2) offer further nutritional counseling, (3) strengthen the relationship between the physician and the patient, and (4) support and reward patients' compliance efforts. 30 references.

81-1066
Patient-Health Education: A Physician's Viewpoint.
Whitehouse, F. W.
In: Patient-Health Education: The Librarian's Role. Proceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 16-20, 1979.

Public librarians can contribute to health information and patient education efforts by providing information on promotion and maintenance of good health to nonpatients and information on surviving or coping to those with chronic diseases. Issues surrounding information preparation and dissemination by librarians include choosing topics and sources; distinguishing between scientific facts and traditional opinions; selecting methods of presenting information; selecting audiovisual resources; balancing viewpoints in controversial health areas; identifying obsolete materials and replacing them with updated ones; avoiding duplication in materials; offering evaluative comment on educational materials; maintaining funding for health information services; and considering factors such as ethnicity, language differences, age, and levels of literacy. Librarians should distinguish between presenting facts and offering perspectives, use the opportunity for motivating clients, and suggest appropriate applications of knowledge. Librarians can also play a prominent role in health information promotion and outreach by supporting school health curricula, home television exposure, and use of educational materials supplied by voluntary health agencies in libraries. Information and education activities for diabetics are cited as examples.

81-1067
From Educating the Diabetic Client to the MoNA Clinical Sessions.
Woods, M. E.
Missouri Nurse 49(3):10-11, June-July 1980.

In October 1980, the Missouri Nurses Association (MoNA) Special Interest Groups conducted a series of weekend sessions on patient education. The medical-surgical special interest group sponsored 1-day workshops on "Patient Teaching: What Do Nurses Need to Know?" at four sites in Missouri during fall 1978. During these sessions, participants worked in small groups to develop teaching plans based on individual case studies. Ten different teaching plans resulted from the groups' work, reflecting the variety of the case-study situations. A diabetic teaching program was developed that teaches the patient to follow the treatment regimen and to assume self-care responsibility. Program topics include the initial diagnosis

of diabetes; anatomy and physiology of diabetes; precipitating factors in diabetic reactions; diet; medications; activity; and discharge instructions. Objectives, teaching activities, and evaluations or outcomes are provided for each topic.

PROFESSIONAL EDUCATION AND TRAINING

81-1068
The Self-Care Training Nurse: Moving the Renal Patient From Basic Acceptance to Competence.
Deeg, D.
Nephrology Nurse 2(4):22, July-August 1980.

The educational responsibilities of the self-care training nurse treating the renal patient include planning, organizing, and coordinating the hemodialysis and home-training program. At least 3 months of experience in assisting patients on maintenance dialysis is required, and a year of experience in a special nursing area is preferred. Background in interpersonal communication, family therapy, and death and dying curricula is helpful. The nurse must be able to work as part of a team that includes a nephrologist, the administrative manager of the renal department, renal technicians, a dietitian, a patient representative, a unit secretary, renal staff nurses, and representatives of companies that supply home patients with water and other supplies. Weekly interdisciplinary conferences allow assessment of the ability of the patient and the family to implement the care plan. Home visits and the use of carefully documented quizzes and checklists administered to the patient and a significant other are essential. Each renal unit should have an inservice program to ensure that nurses are properly trained in these areas.

81-1069
School Nurse Certification With a Health Education Minor Option.
Johnson, J. N.
Journal of School Health 49(2):70-71, February 1979.

The University of Wisconsin at Madison offers undergraduate nursing students, graduate nurses, and practicing school nurses a program of study leading to certification as a school nurse. The program includes an optional component that allows students to obtain a 26-credit minor in health education and a certification of eligibility as a health teacher. Requirements for certification as a Wisconsin school nurse include a Bachelor of Science in nursing, a six-credit practicum in school nursing, and nine credits in education. Practicum students meet in bimonthly seminars to discuss experiences and research topics, formulate a sound nursing philosophy, plan future programs, and evaluate existing health education programs. Field placements available to program graduates include employment as school nurses attached to one school or employment by a health department or nursing service to provide services to schools that do not have full-time nurses.

81-1070
Teachers and Pupils as Health Workers.
Joseph, M. V.
Lancet (London) 2(8202):1016-1017, November 8, 1980.

A program in the pediatrics department of a hospital in rural central Kerala, India, trains teachers and pupils in health care, illness prevention, and health promotion activities. The target population for recruitment includes teachers and pupils at 30 schools within 20 kilometers of the hospital. The first phase of the four-phase program involved attendance by teachers at a 4-day course, establishment of school health units with simple medicine and first-aid facilities, and establishment of linkages between the hospital and schools via a health visitor. During the second phase, 6 to 10 pupils from each school were trained to assist the teacher and promote healthy behavior among peers. The third phase, community action, consisted of numerous student-run prophylactic, immunization, nutrition, dental hygiene, and sanitation projects. Finally, the student trainees were encouraged to involve their families, particularly siblings, in healthy behaviors. A 5-year program evaluation revealed a substantial reduction in common ailments among the target population and a rise in student attendance at school. 4 references.

81-1071
Maxcy-Rosenau Public Health and Preventive Medicine.
Last, J. M., ed.
11th ed. New York, Appleton-Century-Crofts, 1926 p., 1980.

An overview of the field of public health and preventive medicine is presented for students in schools of public health and for residents in preventive or community medicine. Topics include public health methods; communicable diseases; environmental health; hygiene and sanitation; behaviors affecting health; chronic disabling conditions; mental health and mental disorders; genetic aspects of preventive medicine; dental public health; nu-

trition and preventive medicine; population and public health; injury as a public health problem; and health care planning, organization, and evaluation. Numerous references.

81-1072
"What is Health Education in Nursing Practice?" Report of a Developmental Workshop, December 1979.
Perkins, E.
London, England, Health Education Council (Training Occasional Paper 2), 26 p., May 1980.

In December 1979, the Health Education Council of London, England, held a developmental workshop to delineate the role of health education in nursing practice. The 39 workshop participants, who included district nursing officers, directors of nurse education, nurse tutors, area health education officers, and one regional nurse, were divided into groups to address questions related to nursing syllabi; the contribution of the health education officer to curriculum development; support networks; professional inhibitions affecting the nurse's natural ability; factors influencing interaction between tutors, managers, and students; factors inhibiting effective nurse-patient communication; strategies for improving communication; networks for support among patients; the relation between the nurse's health education role and counseling and teaching functions; and the contribution of the health education officer in supporting the health education role of the nurse. Lists of workshop delegates and planners, a booklist for health education in nursing practice, and miscellaneous workshop materials are appended.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-1073
Legal and Ethical Issues Involved in Health Education.
Goldberg, T.
In: Patient-Health Education: The Librarian's Role. Proceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 129-132, 1979.

Legal issues in medicine center on the rights and obligations of the physician in treating symptoms presented by a sick patient. Legal proceedings result when desired outcomes are not forthcoming, indicating that the provider somehow violated legal responsibility to adhere to an accepted course of action that would have resulted in cure. This one-sided approach is a reflection of the predominant view that medical care should be directed at attending disease. Little attention is given to patients' roles in the process, including their rights and responsibilities. Evidence indicates that economic circumstances, environmental factors, self-imposed risks, health education, and general attitudes have a substantially greater impact on health status than does the lack of technical expertise or limited medical care services. Medicine must go beyond responding to the demands for acute care and encompass preventive medicine and health education as more effective tools for dealing with major health threats. Measures for improving the overall health of the American people should include an emphasis on health promotion rather than on treatment of disease, adequate acknowledgment and compensation for those who provide preventive services as well as for those who perform curative procedures, an increase in health education programs and activities, and a broadening of the definition of legal and ethical issues in health care.

81-1074
Statement of Nutrition Education Policy. Board of the National Nutrition Consortium, June 1980.
National Nutrition Consortium, Washington, D.C.
Journal of Nutrition Education 12(3):138-139, July-September 1980.

In June 1980, the National Nutrition Consortium Board, with the aid of the Society for Nutrition Education, formulated a statement on nutrition education policy. The policy suggests that (1) nutrition education be incorporated into all educational levels; (2) adult education programs be improved, with the goal of improving the home nutrition environment; (3) nutrition education be conducted or supervised by professionals who have had scientific training in nutrition through accredited institutions; (4) the content of nutrition education be based on scientific evidence and, where appropriate, should present both sides of a controversial issue; (5) all nutrition education efforts include an evaluation component to assess attitudinal, cognitive, and behavioral change; (6) adequate funding for continuing research in nutrition education be made available from public and private sources; and (7) activities be coordinated by all professionals in the field.

81-1075
Health Education as an Element of US Policy.
Ogden, H. G.
International Journal of Health Education (Geneva) 23(3):150-155, 1980.

The U.S. government's role in setting and implementing health policy is outlined. The Surgeon General's report on health promotion and disease prevention, entitled "Healthy People" (1979), focused on lifestyles, health protection, and health services. Specific objectives for the coming decade are defined in 15 major subareas, with health education a critical element in nearly all of them. Along with public disenchantment with the medicalization of health, other factors have contributed to health education's new visibility, including the consumer, environmental, and women's rights movements, as well as a general popular movement toward better health through lifestyle changes. A number of major proposals are being advanced through the budgetary system for implementation of health education and promotion programs, some directed toward specific disease problems and health behaviors, others toward the capability of State and local agencies to carry out effective health education and risk reduction programs. Responsibilities associated with the emergence of health education as a prominent element in national health policy are examined.

81-1076
Common Ground in Health Education.
Ogden, H. G.
Eta Sigma Gamman 12(3):3-6, Fall-Winter 1980.

Health educators must find a common working ground if they are to continue to receive funding and public support. Developments over the decade indicate the rise of government sponsorship for health education: the formation of the President's Committee on Health Education in 1971; delivery of the Committee's Report to the White House in 1973; establishment of the Bureau of Health Education (BHE) in 1974; inclusion of health education among the 10 priorities of the national health planning system in 1975; enactment of Public Law 94-317 in 1976; passage of the Health Services Amendments in 1978; publication of the Surgeon General's 1979 Report outlining a national program of health promotion; and initiation of a health education grant program at BHE in 1979. In response to this support, health educators must formulate evaluation designs that measure how cost-effectively health education programming ameliorates leading health problems. The initial success of the BHE grant program suggests that health educators are capable of finding the common ground necessary for this effort. Other indicators of the discipline's competence include the process of role delineation for health educators now underway under the auspices of the National Center for Health Education, the immense growth of contracts and collaborative efforts involving the Department of Education and the Public Health Service, the growth of the Coalition of Health Education Organizations, and the development of a joint health and education approach to evaluation of school health curricula.

81-1077
A Hard Look at FDA's Patient Labeling Project.
Penna, R. P.
American Pharmacy 19(12):16-19, November 1979.

An adaptation is presented of a formal statement prepared by the American Pharmaceutical Association (APhA) for submission to the Food and Drug Administration (FDA) in response to proposed patient labeling regulations. APhA suggests that the FDA has failed to identify clearly the objectives that patient labeling should achieve and has failed to supply adequate evidence that the proposed regulations will provide any substantial patient benefit. APhA estimates that total expenses incurred by independent and chain pharmacies due to the addition of filing cabinets, remodeling costs, reduced profits and unrecovered rents, additional supply costs, clerk labor, pharmacists' salary expenses, and returned prescriptions will approach $1.8 billion by the end of the 5-year implementation period, based on a 7 percent annual inflation rate. Specific comments regarding dispensing, distributing, and withholding patient labeling are given along with the recommendations that the FDA (1) conduct a more thorough analysis of the proposed regulation containing input from APhA, manufacturers, and wholesalers; (2) join with other government and nongovernment groups to review and analyze the report being prepared by the National Academy of Sciences' Institute of Medicine on the impact of patient labeling; and (3) design a pilot program to test whether patient labeling meets the expectations of the agency, the public, and the health professions.

81-1078
Where Do We Stand With PPIs?
Welsh, J. S.
American Pharmacy 19(12):12-15, November 1979.

A synopsis of the U.S. Food and Drug Administration regulations on patient labeling, an outline of pending proposals to be implemented over a 5-year period, and perceived drawbacks to the new proposals are presented. Drawbacks to the new proposals include (1) the cost of extra physician and pharmacist consultation time needed to overcome patients' misgivings; (2) the cost to pharmacists of refunds for medications patients might elect to return after reading the patient package insert (PPI); (3) additional handling and shipping expenses for drug manufacturers; and (4) additional costs for PPI dispensers. Addi-

tional problems include the possibility of running out of PPI's before depleting the drug supply, and the requirement for PPI's on prescription renewals in the treatment of chronic or medical conditions. Several commercially available drug information leaflets are examined, with the suggestion that the FDA approve such leaflets as PPI substitutes.

RESEARCH AND EVALUATION

81-1079
Case Studies in Behavioral Diagnosis and Management: A Review of Previous Case Studies.
Physician's Patient Education Newsletter 4(1):5-6, February 1981.

A review of 16 case studies in behavioral diagnosis and management suggests possible areas for the continued development of the behavioral diagnosis concept. The concept of behavioral diagnosis organizes human behavior into predisposing (individual), reinforcing (social), and enabling (environmental) factors. Case studies have demonstrated the efficacy of the behavioral diagnosis approach in dealing with asthma, hypertension, birth control, child care, manic depression, and difficult breast feeding. Of the 16 cases reviewed, all but 3 reported on followup visits regarding the effectiveness of patient education activities. Three of the thirteen followup cases described failures of the behavioral interventions. Behavioral diagnosis techniques are particularly effective in identifying impediments to desired behavior. Though case studies preclude the use of controlled designs, they effectively and economically highlight anecdotal findings often missed by standardized, objective evaluation instruments. Future research should investigate nonverbal behavior, proper questioning procedures, and identification of patient anxieties. 17 references.

81-1080
Knowledge and Vocabulary Used in Periodontal Health Education by Students in the Dental Field.
Bakdash, M. B. and Keenan, K. M.
Educational Directions for Dental Auxiliaries 3(2):11-14, May 1978.

To evaluate the knowledge and vocabulary used by dental health students to describe various signs of periodontal disease, 545 dental, dental hygiene, and dental assistant students were asked to list in layman's terms as many signs of periodontal disease as they knew. Each response was subjected to quantitative and qualitative analysis. Quantitative analysis revealed that second year dental assistant students knew significantly fewer periodontal disease signs than any other group. Second year dental and first and second year dental hygiene students knew similar numbers of signs, with first year dental students reporting somewhat lower and third year dental students reporting somewhat higher. Qualitative analysis showed that most students, particularly third year dental students, described disease signs in highly technical language. Limitations and implications of the research as well as further recommendations are discussed. 14 references.

81-1081
A Research Framework for Evaluating the Promotion of Mental Health and Prevention of Mental Illness.
Eisenberg, L.
Public Health Reports 96(1):3-19, January-February 1981.

A review of selected topics in mental health promotion and prevention of mental illness and a consideration of prevention and promotion efforts provide background for evaluating such efforts. Preventive efforts need to be placed in a proper perspective. The decision as to whether or how they will be implemented is often a political one, made without regard to the merits of the effort. Also prevention is often depicted as an eventual eliminator of disease, yet reasonable assertions of the benefits of preventive behavior and realistic evaluative criteria are needed. Tasks for those working in preventive efforts include (1) assessing the illness burden of each category of disease, (2) determining the relationship between nutrition and specific diseases, (3) determining the influence of social networks on psychological and physiological disorders, (4) mitigating the effects of acute loss, (5) determining the influence of school versus social class on health status, and (6) providing responsive programming to adolescents in sex education and family planning. Specific techniques to protect against psychiatric disorders include amniocentesis and abortion, metabolic screening techniques for newborns, genetic counseling services, early interventions for children at risk, means of minimizing environmental hazards to the brain, and primary prevention techniques for mental disorders associated with aging. 136 references.

81-1082
The Consumer Speaks: How Patients Select and How Much They Know About Dental Health Care Personnel.
Garfunkel, E.
Journal of Prosthetic Dentistry 43(4):380-384, April 1980.

To determine what prospective patients consider important when seeking dental care, 268 patients at 22 offices in Dayton, Ohio, were asked to complete a 42-item questionnaire. Seventy-eight of the patients wore complete dentures and answered an additional 24 questions. Results revealed (1) the public needs more familiarity with the different specialties available in dentistry; (2) the meaning of the term "denturist" is not widely known; (3) most patients select a dentist through recommendations of friends and relatives; (4) the most desirable characteristic in a dentist is the willingness to communicate with patients and to discuss alternative treatments; (5) most patients consider dental fees reasonable for the service provided; (6) although most patients have confidence in their dentists, a significant percentage believe that dentists are more concerned with making money than with patient welfare; and (7) dentists refer few patients to prosthodontists, and of those referred, most require a maxillofacial prosthesis. 5 references.

81-1083
Suggested Guidelines for Evaluation of Health Education Programs.
Gunn, W. J.
In: "My Health to Better Living"; Meeting of National 4-H Health Advisory Panel and Pilot States at the National 4-H Center, August 2-3, 1978. National 4-H Council, Washington, D.C., p. 58-68, (197-).

Guidelines are offered for implementing research, demonstration, and service projects and for evaluating these projects. Steps in the evaluation process include (1) identifying a target audience (i.e., those who will experience the program as well as those whose interest and support are desired); (2) determining evaluation purposes, i.e., formative, summative, or political; (3) identifying resources available for the evaluation; (4) identifying a target group; (5) determining program issues and devising means to state program objectives in measurable form; (6) identifying, developing, and validating measurement devices to be used in measuring program outcomes and implementation; (7) identifying, developing, and validating test criteria as a means to compare program content with program objectives; (8) selecting an appropriate experimental evaluation design; (9) collecting and analyzing data; and (10) drafting the final report, with subsequent communication of results to the target audience.

81-1084
Bridging the Gap: Can It Be Done?
Hoffman-LaRoche, Inc., Nutley, N.J. Vitamin Nutrition Information Service.
Nutley, N.J., Vitamin Nutrition Information Service, Hoffman-LaRoche, Inc., 11 p., April 1980.

The Response Analysis Corporation conducted a series of surveys from May through November 1978, to appraise current nutrition beliefs and practices among parents, students, and nutrition educators. The survey samples included 1,000 parents of children under 18 years old, 448 nutrition educators, and 750 students 9-18 years old. Survey results indicated that (1) 95 percent of the people surveyed thought that nutrition was important to their families and themselves; (2) 99 percent of the parents thought that nutrition education was important for children; (3) high scores on a nutrition knowledge test did not correlate with good eating habits among students; (4) eating habits deteriorated as age increased; (5) although students claimed to rely most heavily on teachers for nutrition information, they practice nutritional behavior modeled by their parents; and (6) the erosion of traditional lifestyles has contributed to casual eating habits. Results suggest that specialized training for nutrition educators and emphasis on nutrition education in the schools are needed.

81-1085
Critical Patient Behaviors in High Blood Pressure Control.
McCombs, J.; Fink, J.; and Bandy, P.
Cardiovascular Nursing 16(4).19-23, July-August 1980.

In order to define behaviors critical to therapeutic control of hypertension and to promote active responsibility among hypertensives, the National High Blood Pressure Education Program brought together an interdisciplinary group representing medicine, pharmacy, health education, and nursing. The group's decisions were based on the premise that active patient participation, placement of primary responsibility with the patient, and interaction between the patient and the professional are essential. Critical behaviors identified include making the decision to control blood pressure, taking the medication as prescribed, monitoring progress towards the blood pressure goal, and resolving problems that block achievement of blood pressure control. The group delineated specific knowledge, attitudes, and skills associated with each behavior. The efficacy of the behaviors outlined by the group need to be validated via testing by nurses and other professionals. 6 references.

81-1086
A Study of the Impact of the 1978-79 National Influenza Immunization Program on Specific Physician Groups. Final Report.
Opinion Research Corp., Princeton, N. J.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 355 p., November 1979.

A nationwide survey of 239 general practitioners, 287 internists, 252 pediatricians, and 252 industrial physicians was conducted in 1979 by Opinion Research Corporation under contract with the Center for Disease Control to assess the views of these professionals about the 1978-79 public influenza immunization program. Telephone interviews were conducted from September 5 through October 12. Results of the survey indicated that (1) 90 percent of the physicians administered the flu vaccine; (2) 93 percent thought the vaccine was safe; (3) those who administered the vaccine were most likely to use it among patients with chronic illnesses and elderly patients; (4) 90 percent informed their patients of the risks and benefits associated with the vaccine; (5) fewer than 10 percent found it difficult to obtain the vaccine; (6) fewer than 25 percent were aware that Medicaid reimbursements were available to cover the costs of the vaccine; (7) only 30 percent thought that the average adult should be vaccinated; (8) only 10 percent thought that children should be vaccinated; (9) 47 percent reported dissatisfaction with the program, often due to lack of information or poor program management; and (10) 70 percent supported future programs.

81-1087

Influence of Selection Versus Lifestyle on Risk of Fatal Cancer and Cardiovascular Disease Among Seventh-Day Adventists.

Phillips, R. L.; Kuzma, J. W.; Beeson, W. L.; and Lotz, T.
American Journal of Epidemiology 112(2):296-314, August 1980.

A mail survey of 22,940 Seventh Day Adventists (SDA's) and 112,726 subjects representing the remainder of the California population provided data that may explain the low level of mortality due to cancer and cardiovascular disease among SDA's. SDA and non-SDA participants who were over 35 years old were comparable in that they both had a substantially better occupational and educational status than other whites in the nation. However, the lifestyles of the SDA's were characterized by significantly lower levels of tobacco use, meat consumption, and stress factors, and a significantly higher level of exercise. In comparison to all whites in the nation, the non-SDA Californians had significantly lower levels of mortality from cancer and coronary heart disease. When comparing SDA and non-SDA populations in California, the former have significantly lower mortality rates associated with smoking-related cancers, colon-rectal cancer, circulatory disease, and coronary heart disease. Fatal lung cancer among all nonsmoking SDA's was 50 percent less than the risk among comparable nonsmoking non-SDA's, suggesting that passive smoking may be cancer causing for non-SDA's. The divergence of SDA's from the typical Western lifestyle may be the leading factor contributing to the low mortality rates associated with lifestyle-related diseases for this population. 13 references.

81-1088

Attitudes Toward Abortion and Prenatal Diagnosis of Fetal Abnormalities: Implications for Educational Programs.

Sell, R. R.; Roghmann, K. J.; and Doherty, R. A.
Social Biology 25(4):288-301, Winter 1978.

The relationship between knowledge of prenatal screening and attitudes toward abortion under circumstances of probable fetal abnormalities was examined through questionnaires completed by 1,616 women 30 to 45 years old from the Rochester, New York, area. Results revealed that (1) Catholic women were most likely and Protestant women least likely to be opposed to abortion; (2) 21 percent of all women with one child or less were opposed to abortion, whereas among women with three or more children opposition increased to 29 percent; (3) 31 percent of Catholic women with small families and 37 percent with large families were opposed to abortion; (4) no substantial relationship between family size and attitudes toward abortion was noted among Protestant women; (5) 57 percent of all respondents believed that women over 35 years old should have prenatal diagnosis, and 71 percent believed that women over 40 years old should have such diagnosis; (6) few women were aware of the specific abnormalities detectable before birth; and (7) moral considerations represented only part of the opposition to abortion, and low levels of knowledge about prenatal screening were consistently associated with opposition to abortion. Findings suggest that any action increasing the awareness of prenatal screening benefits would lead to a greater demand for abortion services. 33 references.

81-1089

Sources of Sex Information and Premarital Sexual Behavior.

Spanier, G. B.
Journal of Sex Research 13(2):73-88, May 1977.

A secondary analysis of cross-sectional data from a national probability sample of 1,177 college students, who were interviewed during spring 1967 about their sexual behavior and sexual socialization experiences, was designed to investigate the sources of sex information and the means by which these sources influence sexual behavior. Information was obtained from subjects through structured interviews. The dependent variable in the study,

premarital sociosexual behavior, was measured by an index that registered incidence and prevalence of premarital sexual involvement during college. Reported sources of sexual information and the index were cross tabulated. Among females, sexual behavior was influenced in a positive direction by male friends and independent reading, and in a negative direction by mothers. Among males, sexual behavior was influenced in a negative direction by clergymen and in a positive direction by male and female friends and independent reading. Because only cross-sectional data was available, these findings should be interpreted cautiously. Additional research with a longitudinal design and research investigating content as well as sources of information are needed. 11 references.

81-1090
Nutritional Knowledge and Health Goals of Young Spouses.
Yetley, E. A. and Roderuck, C.
Journal of the American Dietetic Association 77(1):31-41, July 1980.

The first stage of a theoretical adoption model (how individuals respond to stimuli and decide to apply their knowledge in a specific situation) was used to study decision making relevant to the food practices of 116 couples. Included in the study were families with (1) a mother not more than 35 years old, (2) at least one child living in the home, and (3) both parents residing in the home. Spouses were interviewed simultaneously and separately in their homes, and instruments were developed to evaluate each couple's social class level, orientation toward mastery (control of one's fate), nutrition knowledge, and goal orientation (health, social, and economic). Factor analysis was used to check construct validity of theoretical goal orientations and to develop a composite health-goal scale. Pearson product-moment correlation coefficients were obtained to show associations among variables. Finally, the theoretical model was evaluated using a path model (scheme explicitly stating variable relationships). Results of these analyses indicated that (1) wives' mastery-value orientation was positively related to nutritional knowledge; (2) husbands ranked the importance of health and dietary goals lower than the wives did; (3) nutritional knowledge and the importance of health and dietary goals were negatively associated for husbands, but positively associated for wives; and (4) though nutritional facts were probably obtained independently by husbands and wives, goals may have been influenced by family interaction patterns. The path analysis provided rigorous evaluation of the data. By making explicit assumed relationships among variables, future research can be designed so that those relationships can be tested directly rather than inferred from cross-sectional data. 41 references.

RISK REDUCTION

81-1091
Primary Socialisation and Smoking.
Baric, L.
London, England, Health Education Council. Monograph Series, 74 p., 1979.

As one component of three studies carried out in England, 224 mothers with children under 5 years old were studied to investigate the transmission of smoking norms to very young children and the children's awareness of, experimentation with, and exposure to smoking. After a preliminary survey to determine the information that could be gathered from the subjects, a stratified sample of mothers giving birth between 1972 and 1976 was developed. Of the 310 mothers in the sample, 224 were contacted and interviewed by professional interviewers. The structured interviews included closed and open-ended questions. Questionnaire data indicated that (1) the first year of a child's life is the most sensitive period as far as awareness of habits, acquisition of manipulative skills, and imitation and modeling; (2) few parents who smoke are willing to refrain from smoking to provide positive role models for their children; (3) mothers do not seem to understand the mechanism of primary socialization; and (4) both statistical and social norms can influence the behavior of mothers. Rather than ban smoking to create a social norm, it may be sufficient to create a perception of shared expectations about nonsmoking, thereby creating an effective statistical norm. Data on frequency distribution, tabulated data, and a discussion of primary socialization are appended. 19 references.

81-1092
Progress in Reducing Adolescent Smoking (Editorial).
Fisher, E. B.
American Journal of Public Health 70(7):678-679, July 1980.

Several recent studies indicate that smoking among adolescents and teenagers can be reduced. Numerous controlled studies have reported significant decreases in smoking levels among adolescents participating in experiments designed to promote reduction or cessation of smoking. The successful programs have emphasized a positive approach to health, used peer counselors frequently, and refrained from using guilt or fear as tactics. Research in the future should concentrate on analyses of critical components and of the settings that may mediate their effects. Long-term evaluative designs will provide researchers with definitive evidence about the efficacy of

smoking programs. In addition to examining the use of peer educators and counselors, future research should focus on programs emphasizing the immediate physiological effects of smoking. 10 references.

81-1093
Use of Health Education and Attempted Dietary Change to Modify Atherosclerotic Risk Factors: A Controlled Trial.
Goldberg, S. J.; Allen, H. D.; Friedman, G.; Meredith, K.; Tymrack, M.; and Owen, A. Y.
American Journal of Clinical Nutrition 33(6):1272-1278, June 1980.

A study was conducted in two Phoenix, Arizona, elementary schools to determine whether nutrition education on atherosclerotic risk factors would cause schoolchildren to alter their diets to produce significant reductions in risk factor values as compared to a control group. Variables measured included knowledge, serum cholesterol, blood pressure, height, weight, and skinfold thickness. Teachers of students in the intervention group were trained by a nurse and physician consultants; the teachers then developed their own curriculum. Monthly newsletters were sent to parents. The diet of the intervention group was slightly altered by changing school cafeteria selections. At the end of 4 years, complete data were collected from 68 children in the intervention program and from 23 children in a control group from a different school. Although the intervention group registered significant knowledge gains, results showed no significant changes between groups for the other variables, and no changes in the preintervention values (except knowledge) for the intervention population. Results suggest that, although cognitive testing proved the education effective, the method used was ineffective in reducing atherosclerotic risk factors. 14 references.

81-1094
Weight Loss Program in a Student Health Service.
Hidalgo, S. M.
Journal of the American College Health Association 29(2):84-85, October 1980.

A study involving 33 overweight students enrolled at Georgetown University in Washington, D.C., assessed the efficacy of a group weight-loss program employing behavior modification techniques. The nurse practitioner at the student health service organized one group of 16 students in the fall semester and one group of 17 students in the spring semester. Each group met for 1 hour per week for 13 weeks. Women were placed on a 1,000-calorie diet and men on a 1,500-calorie diet. Each diet was supplemented by vitamins. During the meetings, the subjects discussed and planned the use of behavioral techniques to prevent overeating. The program was completed by eight participants in the first group and seven participants in the second group. Six of the students from the first group were contacted during a 6-month followup period and three students were contacted during a 10-month followup period. All students had reached and maintained their desired weight. These results demonstrate that the nurse practitioner can play a vital role in encouraging personal responsibility for health. 5 references.

81-1095
Overnutrition and Obesity.
Lloyd, J. K. and Wolff, O. H.
In: Prevention in Childhood of Health Problems in Adult Life. Falkner, F., ed. Geneva, Switzerland, World Health Organization, p. 53-70, 1980.

Obesity measurement methods, the prevalence and prognosis of obesity by age group, and the etiology of obesity are reviewed as a background for an investigation of preventive measures. Means of measuring obesity include simple inspection and assessment of weight, skinfold thickness, upper arm circumference, and body fat. Etiological considerations related to obesity include genetic, familial, socioeconomic, and emotional factors as well as factors related to energy intake and output. Endocrine and metabolic disorders are rarely causal factors in the development of obesity. Since 33 percent of adult obesity originates in childhood or adolescence, and since obesity in children tends to persist into adult life, prevention during childhood is important. To avoid fetal overnutrition, pregnant women should be instructed to avoid overeating. Maintenance of weight charts helps prevent the overfeeding of infants. Nutrition education should begin early in life and include consideration of social and cultural influences. Physicians and nurses should take part in the nutrition instruction of parents with small children. 84 references.

81-1096
Use of the Adolescent Peer Group to Increase the Self-Care Agency of Adolescent Alcohol Abusers.
Michael, M. M. and Sewall, K. S.
Nursing Clinics of North America 15(1):157-176, March 1980.

Nurses can successfully implement reality therapy (a treatment that leads clients toward dealing with problems in the real world) in adolescent peer groups to enhance

adolescents' self-care abilities and to enable them to resist influences that lead to alcohol abuse. One of the developmental tasks confronting the teenager midway through adolescence is admittance to a peer group. If the adolescent has not accomplished the formation of a stable ego, the peer group often becomes a focal point for alcohol abuse. To ensure proper adjustment to the peer group, the nurse can implement some form of reality therapy to help form a sense of responsible behavior and a sense of right and wrong. In addition, the nurse or therapist must establish a caring relationship with the peer group, identify group behavior associated with alcohol intake, stimulate the group into making a decision regarding drinking, provide assistance to help the group modify the drinking behavior of its members, establish contracts for implementing the plan, and maintain contact with the group. Experiences with the formation and development of an open-ended group of 11 adolescents, 14-20 years old, at an alcohol treatment unit demonstrated that the nurse can be effective in facilitating group dynamics that lead to prevention of further alcohol abuse. 10 references.

81-1097
Reducing Health Risks Through Peer Health Education: A Preliminary Report.
Nagelberg, D. B.; Hodge, J. M.; and Ketzer, J. M.
Journal of the American College Health Association 28(4):234-235, February 1980.

The student health service of Bowling Green (Ohio) State University, has recently initiated the Health Risk Reduction Program to promote student health by increasing self-awareness and personal responsibility for health. The traditional pre-enrollment physical examination has been replaced by a self-reported medical health inventory called the Database Acquisition for Student Health. Data from the inventory is analyzed and students receive a health risk index outlining their health status. Peer health educators, who are selected from groups of upper class or graduate students, counsel the students. Faculty and staff members in the health, nutrition, health and physical education, psychology, social work, and education fields select the paraprofessional peer educators. The candidate educators attend a 10-week course, during which a psychologist and an educator instruct them in health content areas, process skills, and practicum training topics. The potential peer educators also view and evaluate videotaped interviews with students. Each educator interviews four to five freshmen each week. Approximately 300 freshmen are interviewed each academic quarter. A survey of 108 freshmen who met with a peer educator during 1979 and 100 freshmen who received their inventory results through the mail indicated that student attitudes toward the educators are favorable and that the educators clarified students perceptions of inventory results. 7 references.

81-1098
Obesity: Prevention Is Easier Than Cure.
Overfield, T.
Nurse Practitioner 5(5):25-26, 33, 62, September-October 1980.

A review of research on the causes of obesity and the characteristics of obese individuals indicates specific prevention and intervention measures that nurses can incorporate into counseling. Findings with significant implications include the differential occurrence of obesity according to socioeconomic status, sex, age, genetic and familial tendencies, and critical periods in the growth process; the role of nutrition during the various stages of pregnancy and early development in determining lifelong weight patterns in offspring; and the adipose cell theory regarding the critical influence of early nutrition on the number and size of fat cells. When counseling individuals, nurses should distinguish between childhood- and adolescent-onset obesity on the one hand and adult-onset obesity on the other. They should also be aware that reduction of caloric intake and an increase in exercise are the two best methods for weight loss and the maintenance of weight loss, and that exercise is more effective than an equivalent reduction in dietary calories. Nurse-counselors should (1) make parents aware of the consequences of overfeeding their children; (2) include dietary counseling as an integral part of prenatal care; (3) consider the age of obesity onset and the client's social class, while making the causes of obesity known to all parents; and (4) encourage mildly overweight adults to increase their exercise to avoid health problems in later years. 17 references.

81-1099
Changing the Cardiovascular Risk in a Community: The North Karelia Project.
Puska, R.; Koskela, K.; Salonen, J. T.; and Tuomilehto, J.
Health Education (Ottawa) 18(3):7-8, 13, October 1979.

A 1971 petition from the local population of North Karelia, Finland, asking for national assistance to reduce the high mortality rate due to cardiovascular disease (CVD) in that county resulted in the initiation of the North Karelia project in 1972. The project was to consist of a systematic, comprehensive community program to control CVD. The 1972 base-line survey of 12,500 of the county's 180,000 people found that the population was characterized by numerous risk factors associated with CVD. The subse-

quent community intervention strategy involved components to provide information to the public, integrate CVD prevention tasks within existing services, train personnel to provide prevention services, provide environmental services to support desired lifestyle changes, and implement internal information services. The cost-effectiveness evaluation scheme allowed assessment of the changes in risk factors brought about by the program among the middle-aged population and assessment of the resulting changes in mortality and morbidity. Evaluation methods included maintenance of a CVD register, compilation of hospital data on CVD morbidity and mortality, and implementation of representative population surveys. At the end of a 5-year period, a survey of 12,000 persons and a review of other statistics indicated that the program was significantly reducing risk levels and incidence of CVD in the county. The program has been expanded to include other age groups, and further followup studies are planned. 2 references.

81-1100
Prevention in Childhood of Major Cardiovascular Diseases of Adults.
Strasser, T.
In: Prevention in Childhood of Health Problems in Adult Life. Falkner, F., ed. Geneva, Switzerland, World Health Organization, p. 71-85, 1980.

A review of the literature on childhood intervention programs to reduce risk factors associated with cardiovascular diseases identifies strategies aimed at preventing rheumatic diseases, hypertension, ischemic heart disease and stroke, and cardiovascular diseases related to smoking. Primary prevention of rheumatic fever is based on the detection and treatment of streptococcus (group A) throat infections. This step involves bacteriological or clinical surveillance of school classes and other closed communities of children. Such an intervention is particularly crucial in developing countries, where rates of rheumatic fever are high. Primary prevention of hypertension involves screening obese children and children whose parents are affected by hypertension, "tracking" the blood pressures of as many children as possible, screening children for chronic urinary infections, and implementing programs to reduce risk factors associated with hypertension. Risk factor assessment and lifestyle interventions are also the major strategies in prevention of ischemic heart disease. Smoking education interventions in early childhood seem to be the most effective method for preventing cigarette smoking among adolescents. 52 references.

81P-1101
Alcohol Education Project (AEP).
Eckert, P. S.
Southern Illinois University at Carbondale, Student Wellness Resource Center, College View Dorm, 408 W. Mill, Room 13, Carbondale, IL 62901
Funding Source: Illinois State Dept. of Mental Health and Developmental Disabilities, Chicago. Div. of Alcoholism.
August 1978 - Continuing.

The Alcohol Education Project (AEP) of the Student Wellness Resource Center at Southern Illinois University at Carbondale was established to promote a campus environment that discourages irresponsible alcohol use. Services, which are provided by professionals and trained peer educators, include (1) educational sessions on such topics as alternatives to alcohol, and myths and fallacies about alcohol and drinking; (2) training workshops for residential hall staff and health professionals; (3) media and informational campaigns utilizing radio, television, papers, posters, and pamphlets; (4) a resource library; and (5) referral services for individuals or families experiencing problems with alcohol. AEP participates in the replication of a college alcohol abuse prevention model, a project initiated by the National Institute on Alcohol Abuse and Alcoholism. Southern Illinois University is one of five universities in the United States currently field-testing the model. The model's intensive educational and nonthreatening approach helps small groups of students examine their own alcohol use and attitudes. More than 100 single group sessions have been held during AEP's first 2 years, reaching over 2,700 students out of a total population of 22,000. The program cooperates with the student health program, university housing, and the student center. Synergy, a nonprofit community agency, is contracted to provide peer counseling and crisis intervention services. Evaluation procedures began with an informal needs assessment. A consumer survey involving a random sample of 1,000 graduate and undergraduate students is conducted annually to elicit their drinking behavior and attitudes. Participants in all programs complete evaluation forms, and the skills of peer educators are assessed before and after training.

81P-1102
California Prevention Demonstration Program: "Winners."
California State Dept. of Alcohol and Drug Programs, 111 Capitol Mall, Sacramento, CA 95814
March 1977 - December 1980.

The California Prevention Demonstration Program, or "Winners," is a 3-year primary prevention effort designed

to prevent individuals from developing drinking behavior that is detrimental to their health; causes family, social, or economic problems; or creates a financial burden for the government. The program develops and disseminates messages for television, radio, and billboards; curricula and classroom materials; and materials for community activities. Materials developed include posters, slide-tape presentations, handbills, and flyers. The overall population of three communities, one of which served as a control, were targeted. The primary community received both media efforts and community organization efforts; the secondary community received only media messages. Individual media and community presentations were aimed at specific subgroups, such as young men, women 25 to 40 years old, teenagers, parents of teenagers, and minorities. The community component of the program worked closely with the Ganadores Project, a similar program geared to the Spanish-speaking community. The program established contracts with Pacificon Productions for media development and dissemination, the Alcohol Abuse Prevention Program for community organization and development, and the Social Research Group of the School of Public Health of the University of California for evaluation. Evaluation efforts consisted of collecting social indicator data about alcohol-related problems, conducting ethnographic studies, and conducting general population sample surveys. Survey results indicated that (1) awareness of alcohol-related messages and knowledge about alcohol consumption increased; (2) recognition and understanding of program themes and messages was widespread; and (3) there were no changes in attitudes toward drinking or drinking behavior. The program had an annual budget of $850,000.

81P-1103
Heart to Heart.
Deatrick, D. A.
Maine Department of Human Services, Office of Dental Health, State House, Augusta, ME 04333
Continuing.

The Heart to Heart adult education course attempts to improve the cardiovascular awareness and fitness of participants. The 6-week course consists of six 2-hour modules dealing with the risk factor theory of heart disease. Topics include anatomy and physiology of the circulatory system, diet, exercise, smoking, stress, and cardiopulmonary resuscitation. A team of almost 20 volunteers and the course coordinator attend two planning meetings prior to course initiation, and a followup meeting is held a week after completion of the course. Team members for each module prepare a lesson plan and identify specific educational materials to be used. Once the guidelines are completely refined, the course will be used in educational efforts throughout Maine. The staff includes three health educators, seven physicians, a yoga instructor, the director of the Department of Human Services, the director of the Maine Lung Association, a physical education instructor, a physical therapist, and an occupational therapist. Course coordinators include a registered nurse, a staff member in the Office of Dental Health of the Department of Human Services, the director of program development for the Maine affiliate of the American Heart Association, and the coordinator of community health services of the Augusta General Hospital. Evaluation is conducted via pre- and postprogram tests, a background risk assessment, a patient history questionnaire, and a course evaluation form. Faculty staff assess program strengths and weaknesses in coordination, promotion, and course structure. Tabulations of evaluation results are available.

81P-1104
HELP (Health Evaluation and Longevity Planning) Foundation.
Friedman, G. M. 7300 4th Street, Scottsdale, AZ 85251
July 1975 - Continuing.

The HELP (Health Evaluation and Longevity Planning) Foundation was founded to develop a health improvement system for use by businesses in the Scottsdale, Arizona, community, based on a needs assessment or a health examination process. The foundation is a private, nonprofit corporation whose program involves risk factor screening for each participating employee's family, discussion of screening data with the family, implementation of a personalized educational intervention program for each family member, provision of family counseling services aimed at reducing risk factors, and initiation of evening and lunch-hour education and exercise programs. Employers receive group analyses, but no information on any individual employee. The foundation produces numerous pieces of literature to support its activities. A selected list of HELP clients includes 95 corporations, university faculty associations, public agencies, colleges, nonprofit organizations, hospitals, civic groups, church groups, school districts, and other organizations and agencies.

81P-1105
Personal Health Appraisal Program.
Rosenberg, R.
Institute for Personal Health, 2100 M Street, N. W., Suite 316, Washington, DC 20037
Continuing.

The Personal Health Appraisal Program informs individuals about their personal health status and lifestyle risk factors in order to prompt lifestyle changes that enhance health and wellness. The program is operated by the Institute for Personal Health, a private, nonprofit organization of health professionals engaged in programs for health improvement and research. For a nominal fee, a health status appraisal questionnaire is administered to applicants by mail. Returned questionnaires are evaluated through a complex computation process that compares each applicant's data with national standards and other scientific data. The applicant receives a confidential, 46-page personal health appraisal report by mail. The report provides the applicant with a thorough assessment of personal health status. Seminars and courses are offered to support people making the recommended behavioral changes.

81P-1106
Physical Fitness-Heart Disease Intervention Program.
Bjurstrom, L. A.
New York State Education Department, Room 171 EBA, Albany, NY 12234
1972 - Continuing.

The Physical Fitness-Heart Disease Intervent on Program promotes cardiovascular health and fitness among New York State Department of Education employees, who are generally confined to a sedentary work environment. The focus of the program is a 15-week primary behavior and lifestyle modification program consisting of a progressive, physical conditioning regimen requiring 75-minute workouts for 3 days each week. The physical conditioning program is complemented by eight 60-minute health and wellness promotion seminars. A continuing secondary intervention program reinforces previously incorporated lifestyle modifications and provides for further behavior modification. Before entering the program, each participant receives a thorough physical examination and is administered a questionnaire that assesses family history and health-related lifestyle habits. The program is available to employees for a $50 entrance fee, with a yearly renewal charge of $30. During its first 5 years, the program had 800 participants, or 33 percent of the departmental staff. Records are kept on rates of participant adherence to the program, levels of employee sick leave, and participant risk factor modifications estimated via the Michigan Heart Association Risk Factor Estimator. Analysis of these records has indicated that (1) primary program retention improved from a 75 percent rate to an 86 percent rate by the program's sixth session; (2) the retention rate had slipped to 25 percent by the fifth program year; (3) the average sick leave taken by participants dropped significantly after entry into the program; (4) the mean sick leave of participants was lower than the mean for all other State employees; and (5) participants experienced significant reductions in risk factor indices.

81P-1107
Project Life.
McAuliffe, J. A.
Sauk Prairie Memorial Hospital, 80 First Street, Prairie Du Sac, WI 53578
Continuing.

Project Life is a community health promotion program designed to improve nutrition and initiate lifetime exercise programs among participants. The program offers an eight-session weekly course for approximately 30 people that includes sessions on lifestyle risk factors, exercise, nutrition, smoking, stress, health monitoring and screening, and alcohol and drug abuse. Each 60- to 90-minute session includes a question-and-answer period, a film, a discussion of issues raised in the film or in handouts, a flexibility exercise period, and a 30-minute group exercise period. Pulmonary lung function, blood pressure, height and weight, blood cholesterol, and high density lipoprotein are measured. These tests are administered at the beginning of the program and 3, 6, and 12 months later. Participants with two or more risk factors are referred to their personal physician to determine further testing requirements. The program was first implemented in Sauk Prairie, Wisconsin, a two-community district with a total population of 5,000 and a hospital with a service population of 20,000 people. The course, retesting evaluations, and followup assessments are offered at $300 per participant.

81P-1108
Project PRIDE (Positive Results in Drug Education).
Rosenwald, P. R.
Association for Jewish Children, 1301 Spencer St., Philadelphia, PA 19141
Funding Source: Coordinating Office for Drug and Alcohol Abuse Programs for the City of Philadelphia, Pa.
1970 - Continuing.

Project PRIDE (Positive Results in Drug Education), a primary drug abuse prevention program, was developed in 1969 to help fifth, sixth, and seventh grade students examine factors that underlie their drug problems, such as decision making, peer pressure, self-respect, and human relationships. Small group counseling sessions are used and run for 12 weeks. Each session has 11 students and is led by a prevention specialist. The environment of the

group is structured, but the content of the sessions is open. Methods used include open discussion, nonverbal group techniques, and values clarification strategies. Focal areas in the discussions include self-esteem, peer influence, relationships with adults, and decision making. Small parent groups are conducted concurrently. The program also works individually with teachers to impart counseling skills and works with groups of teachers during formal inservice courses to help them develop a humanistic and holistic approach to drug abuse prevention in the classroom. Program staff are available for process consultations with school personnel, and a community-based program provides small group education and training programs for neighborhood groups. The target group includes children, parents, teachers, and other professionals and community members. Workshop participants complete evaluative questionnaires.

81P-1109
Volunteer Resource Development Program.
Halford, R. Y. and Reduka, G. G.
Georgia Citizens Council on Alcoholism, Inc., 2045 Peachtree Road, N.E., Suite 320, Atlanta, GA 30309
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.
October 1978 - Continuing.

The Volunteer Resource Development Program (VRDP) is designed to prevent alcoholism in Georgia through early intervention strategies, education, and treatment of alcoholics. The program is administered by the Georgia Citizens Council on Alcoholism, a statewide, private, nonprofit corporation. VRDP assesses the community's most urgent needs in the area of alcoholism and alcohol abuse and involves volunteers in responding to these needs. Depending on the community, these responses can include education and prevention programs, advocacy for the Uniform Act (legislation securing funding for 28-day residential care facilities for alcoholics), volunteer assistance for treatment centers, and miscellaneous activities such as sponsorship of volunteer training workshops and publication and distribution of literature on alcoholism. The population of Georgia is the target audience. The estimated cost of the project is $120,000, and funding is provided by Federal health grants.

SCHOOL HEALTH EDUCATION

81-1110
Innovative First Aid and Safety Instruction.
Burckes, M. E.
Health Education 11(4):23-24, July-August 1980.

When teaching first aid in the classroom, four objectives should be emphasized: knowledge of the material; a mastery of skills that will be used in the future; attitudinal change; and an understanding of controversial topics. Effective ways to teach first aid include lectures, textbook assignments, audiovisual aids, and skills practice. Possible student projects include constructing posters, bulletin boards, or charts on specific topics; drawing fire escape routes; demonstrating the use of fire extinguishers; and constructing a scrapbook of common accidents and their prevention. Simulated accidents allow students to practice bandaging and splinting skills. In addition, mouth-to-mouth resuscitation, water safety, emergency rescue and transportation, and bleeding control should be examined. Guest speakers, including police and ambulance attendants, persons working in emergency centers, and medical professionals who can explain emergency childbirth or pet first aid, can provide an understanding of available emergency medical services. A list of free films is provided.

81-1111
The School Health Curriculum Project.
Bureau of Health Education (DHHS, CDC), Atlanta, Ga. Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education (HHS Publication No. (CDC)80-8359), 52 p., December 1977, reprinted July 1980.

An overview is provided of the School Health Curriculum Project (SHCP), written through the cooperative effort of the Bureau of Health Education and the National Heart, Lung, and Blood Institute of the National Institutes of Health. Topics include the relationship between health behavior and health education; SHCP systems and education; appreciation and understanding of the body as the subject matter of SHCP; structure and function of SHCP; teacher-training programs associated with SHCP; initiation, maintenance, and extension of SHCP; and evaluation of the benefits of SHCP.

81-1112
Death Education: Accountability Through Scholarly Inquiry.
Crase, D.
Journal of the American College Health Association

27(5):257-260, April 1979.

Expansion of death education, which has been attracting an increasing number of professionals, should be accompanied by a careful delineation of course objectives, teaching strategies, and assessment techniques. Existing research in the field is limited in scope and usually suffers from small sample populations, inadequate instrumentation, and methodological flaws. Current research has focused on degrees of attitude change among students who have completed a course in death education. While the results of these studies reflect some degree of variance, they suggest that instructional units have an impact on students' behaviors. Formal instruction seems to alleviate anxiety among students about discussing suicide, euthanasia, funerals, and other death-related topics. Research conclusions are less definite about students' abilities to deal with fear concerning their own deaths or the management of personal losses. Future research should also investigate the long-term effects of thanatology courses and the effect of inadequate teaching of such courses. Thanatologists must strive for more accountability through the process of scholarly inquiry in order to make death education a lasting and useful concept in education. 31 references.

81-1113
The Role of the Pediatrician in the Adolescent's School.
Duke, P. M.
Pediatric Clinics of North America 27(1):163-171, February 1980.

A review of current methods and new modes of pediatrician involvement in the school is presented. Two basic school health models are (1) the interpretive medical service model, in which pediatricians consult educators about individual students and overall student health, including the issues of students with special needs, health policy, and sports medicine; and (2) the direct medical service model, in which health care is delivered to schools which lack adequate medical care for adolescents. In some direct service programs, pediatricians provide direct care within the schools, while in other programs the pediatrician acts as a consultant in the training of nurse practitioners and provides continual assistance in the diagnosis and followup of patients. The role of educators, peers, parents, and pediatricians is discussed relative to the potential sources of health education available to adolescents, the pediatrician's interaction with these sources, and adolescent learning methods. 43 references.

81-1114
Peanut Butter and Pickles: A Nutrition Program for Pint-Size People.
Ehlert, J.; Johnson, J.; and Caughey, C.
Eureka, Calif., Department of General Education-Nutrition, Humboldt County Office of Education, 407 p., 1979.

Guidelines and lesson plans are provided for a comprehensive nutrition education curriculum for students in grades 1-6 at rural schools. The curriculum includes games, activities, recipes, and activity sheets. The curriculum emphasizes the use of available materials for lesson enrichment. Its three major components are the lesson plans and activities for students, teacher guidelines to introduce the educator to nutrition education teaching techniques, and "nutrition action packs" for use by parents and children. The lesson plans cover food choices, factors that influence food choices, ways of handling food, careers in food and nutrition, and consumerism. Supporting materials include the activity sheets, bulletin boards and other visual aids, puppet shows, games, and materials such as newsletters to encourage parental involvement.

81-1115
Consumer Impact of a Cold Self-Care Center in a Prepaid Ambulatory Care Setting.
Estabrook, B.
Medical Care 17(11):1139-1145, November 1979.

The Cold Self-Care Center was developed at the University of Massachusetts in Amherst as an alternative to professional care and to encourage more active consumer involvement in medical self-care. The center provides patients with criteria for seeking professional help for the common cold, emphasizes the limited nature of the illness, and recommends home remedies and over-the-counter medications. A sample of the user population was compared with a random sample of nonusers, and the program was evaluated for cost, consumer satisfaction, and impact on behavior, knowledge, and attitudes. Center users demonstrated higher knowledge levels about cold care, indicated more dependency on professional resources, and differed in health-related attitudes and cold-care behavior when compared to nonusers. Knowledge of criteria for seeking professional care was greater in nonusers; of the 20 percent of the center users who sought professional care, only 6 percent anticipated seeking professional care for future colds. Satisfaction with the program was high, with speed and ease of use cited most often as reasons for satisfaction. The center also had a favorable impact on campus clinic costs. The findings are discussed as they relate to broader issues of health care delivery. 8 references.

81-1116
Occupational Health Education in the Schools.
Feldman, R. H. L.
Journal of School Health 50(7):428, September 1980.

Attention has focused on the safety and health of American workers since the passage of the Occupational Safety and Health Act in 1970; the topic should also be emphasized in the classroom. By incorporating occupational health in the school health curriculum, students with specific health concerns can evaluate health and safety risks when choosing an occupation. In developing such a program, emphasis should be placed on risk assessment analysis. Case study descriptions of individuals who have had work-related injuries or have contracted occupational illnesses, combined with information on occupational safety and health statistics, would be more effective in increasing student awareness of occupational risks than health and safety statistics alone. 5 references.

81-1117
Comprehensive Health Education Management Model.
Florida State Dept. of Education, Tallahassee.
Atlanta, Ga., U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, 81 p., September 1980.

The Florida Comprehensive Health Education Management Model promotes a multifaceted approach to uniting State health and State education resources to improve comprehensive school health education in grades K-12. It has resulted from a 10-year joint effort headed by the Florida Department of Education and a contract with the Bureau of Health Education. The model can help health education managers in other States (1) utilize their official, professional, and voluntary health and educational resources to improve health education, and (2) promote health education as an integral component of a State's health and education plans. In Florida, health education categorical funding is allocated according to student population and designated specifically for salaries of district health coordinators, inservice training, curriculum design, testing of innovative health education concepts through pilot projects, development or acquisition of instructional materials, technical assistance, and monitoring and evaluation. This funding allocation encourages local school districts to replace fragmented health teaching with sequentially planned comprehensive health instruction throughout a student's education. The model is based on five major management functions that must operate at the State, regional, district, school, and classroom level, namely, advocacy, clearinghouse, coordination, evaluation, and innovation. Key aspects of the program are a permanent advisory and technical assistance structure at the State, regional, and local levels; instructional programs developed by local school districts, and collaboration with community agencies and resources.

81-1118
Comprehensive Health Education in New Mexico Public Schools; A Community Action "Manual," 1978-1980.
Grace, H.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 33 p., September 1980.

The Comprehensive Health Education (CHEd) program in New Mexico provides a comprehensive, sequential health education curriculum for public school students and coordinates health instruction with health services. The priority targets for CHEd programming are heart disease, accidents, and dental and periodontal disease. The State Board of Education has included CHEd programming in its Minimum Educational Standards. Still, local support is needed to ensure the introduction of CHEd programming in all 88 school districts in the State. At a minimum, CHEd programming should be used for nutrition; human growth; family health; health maintenance; consumer health; environmental health; community health; and mental, emotional, and social health. The Community Health Council represents an effective means of organizing CHEd integration into school districts. The Council should inform itself concerning CHEd, determine the extent of health education programs in local schools, conduct a needs assessment, develop a Council statement on CHEd, approach school boards formally to request that CHEd be implemented in district schools, and work with school personnel to formulate an implementation plan. State legislation and synopses of pilot projects are appended. 3 references.

81-1119
A Dental Health Program for Fifth Graders: Results After Three Months.
Huntley, D. E.
Dental Hygiene 53(8):380-382, August 1979.

A 2-week dental health education program for 125 fifth graders at the Goddard Middle School in Wichita, Kansas, was evaluated 3 months after the program ended. The program was coordinated by the school nurse and taught by the nurse and senior dental hygiene students. It used films and included lessons on brushing, flossing, replacing missing teeth, using fluoride, and dealing with malocclu-

sion. The level of plaque on each student's teeth was measured periodically during the program and at the time of the evaluation. The number of students who had removed all plaque from their teeth increased during the program and did not decline significantly after 3 months. The instructors and students were generally enthusiastic about the program. 23 references.

81-1120
Child Development and Health Education.
Kegan, R.
National Elementary Principal 57(3):91-95, March 1978.

A health education curriculum for children and adolescents may be tailored to the information needs of children at different age and developmental levels as expressed through the questions they ask about health. Piaget's theories provide the basis for understanding how the developing child continuously organizes a regular sequence of realities in which to live. Curriculum development should be an effort to join an activity that is natural to the learner and independent of formal education. The different perceptions between children in various grades are not primarily differences in the amount of their information or knowledge, but a reflection of different realities and self-constructed philosophies of life. A health education curriculum will not be a positive experience if it is imposed arbitrarily from the outside; rather, it should address the issues intrinsic to a child's worldview and adjust to the different ways that children view themselves and make meaning of the world at various points in their development. The progressive levels of children's cognitive, social, and interpersonal development are discussed.

81-1121
A Health "Happen-In Booth" in the Campus Center.
Parker, D. F.
Journal of the American College Health Association 28(6):359, June 1980.

The Student Health Services Center at Houghton College, New York, organized a county-wide health fair that resulted in the establishment of a monthly minifair in the form of a Health Happen-In Booth. The booth is set up in the campus center lounge and emphasizes a different aspect of health education each month. The exhibits, staffed by various medical and health education professionals, have increased awareness of health issues and use of the Student Health Services Center.

81-1122
Turning the Tide of Teenage Smoking.
Piper, G. W.
Canadian Journal of Public Health (Ottawa) 71(3):161-162, May-June 1980.

Surveys implemented since 1969 have described the smoking habits of eighth grade students in the Saskatoon Rural Health Region of Canada. The most recent survey, implemented in October 1979, involved 418 boys and 389 girls. Though the number of regular and occasional smokers increased from 1969 to 1973, the numbers decreased between 1973 and 1978 for occasional and regular smoking among boys and for regular smoking among girls. Hence, the trend toward early smoking among adolescents that characterized the early 1970's appears to have reversed. This is most likely the result of smoking education provided to these students in earlier grades and would explain the time lag between the beginning of antismoking education in Canada (in the form of the 1966 Health and Welfare Department's Smoking and Health program) and the decline in smoking among adolescents. 4 references.

81-1123
Health and Science Education: A Natural Partnership (Between Consenting Curricula).
Raw, I. and Rockwell, P.
National Elementary Principal 57(3):85-90, March 1978.

A comprehensive health curriculum for elementary and middle schools should link health and science courses. Most health and science courses are overly concerned with transmitting information in the form of terms and definitions, and the material learned never becomes an integral part of the students' behavior. An effective educational resource which integrates these disciplines and promotes direct student involvement in the learning process is the Elementary Science Study (ESS), which provides a range of projects designed to promote exploration of a topic by means of simple experiments performed with inexpensive materials. The open-ended projects demand observations that will lead to conclusions and further experiments. A number of science activities that can be integrated with learning about nutrition and other health concepts include growing mold and bacteria, using a microscope, raising flies and rats on various experimental diets, performing simple chemical analyses such as measuring the nutrients and caloric content of foods, and performing experiments that demonstrate the principles of probability as they relate to heredity. Formulating and planning new experiments and observing and critically evaluating the results can lead to the formation of a scien-

tific attitude that cannot be acquired through lectures or other traditional methods of teaching. Ideally, it should help children become wise health care consumers who are able to make informed, decisions. 7 references.

81-1124
Death Education: Help or Hurt?
Rosenthall, N. R.
Clearing House 53(5):224-226, January 1980.

Teachers must prepare themselves adequately for death education to ensure that it is a helpful rather than a negative experience for students. Few teachers have knowledge or training in this area and most need to be made aware of the complexity of death education and the problems they may encounter during class sessions. While some death educators may be capable of both counseling and teaching, those who teach about death should learn when to refer students to other appropriately qualified individuals. Death educators should be able to demonstrate basic skills in listening and communicating about death and should be aware of their attitudes and beliefs about death. Several questions for teachers to ask themselves are provided in areas such as their personal feelings toward death, competency to teach the subject, controversial issues related to death, handling emotional reactions of students, classroom learning activities, and affective responses and communication skills. 13 references.

81-1125
Marijuana: Assessing the Cost.
Seffrin, J. R.
Science Teacher 47(4):29-32, April 1980.

The controversy surrounding marijuana use provides science teachers with an excellent opportunity to promote intelligent decision making and values clarification among students. All students should be encouraged to assess for themselves the risks and benefits of using any drug. Concerns about the possible harmful effects of marijuana include potential birth defects from chromosome breakage; brain damage; amotivational syndrome; psychosis; impaired sexual function from lowered testosterone levels in males; reduced immune response; and heart and lung impairment. A systematic review of studies on the possible injurious health effects of marijuana may inform students about the nature of current research and motivate them to follow future research results. When discussing an enlightened approach to decision making about marijuana, teachers should promote an understanding that (1) all environmental influences have an impact on people; (2) what happens later in life is related to decisions made during youth; and (3) what happens in the present and the future is often a matter of personal choice. Several studies on marijuana use are reviewed. 29 references.

81P-1126
Assemblies on the Medical Effects of Smoking.
Reif, A. E.
Boston City Hospital, Volunteers for Health Awareness, 818 Harrison Avenue, Boston MA 02118
September 1968 - Continuing.

Assemblies on the Medical Effects of Smoking, a volunteer effort of the Boston City Hospital and the Department of Pathology of the Boston University School of Medicine, was initiated to prevent the onset of smoking among junior high school students in the Boston metropolitan area. Presentations on the effects of cigarette smoking are given to groups of 100 to 350 adolescents 12 to 14 years old upon requests from area schools. Each presentation consists of a lecture illustrated with color slides, a brief film, and a discussion session. Between 4 and 12 weeks after an assembly, students are given a 24-item evaluation questionnaire to note their reaction to the assembly, their smoking habits prior to the assembly, and any changes that occurred in their smoking habits after the assembly. The sheet also elicits their reasons for beginning to smoke or for disliking smoking. Data from the sheets are coded onto computer cards. Analysis of over 4,500 cards indicated that 40 percent of the student smokers quit immediately after the assembly, but that 33 percent of the quitters were smoking again after 3 months.

81P-1127
Comprehensive School-Community Health Education Project.
Carlyon, P. and Burger, M.
National Congress of Parents and Teachers, 700 North Rush Street, Chicago, IL 60611
Funding Source: Bureau of Health Education (DHHS, CDC), Atlanta, Ga.
1975 - 1980.

The Comprehensive School-Community Health Education Project (CS-CHEP) has attempted to increase community awareness and understanding of health education needs and resources and to develop support for more effective health education in schools and in the general community. During the first 2 program years, pilot projects in six States (Arkansas, California, Colorado, Georgia, Indiana, and Pennsylvania) developed public awareness strategies promoting comprehensive health

education. The pilot phase culminated in a national meeting in January 1978, attended by officers of all State parent-teacher associations and parent-teacher-student associations, along with representatives of national organizations. Nine States (Arkansas, California, Florida, Idaho, New Hampshire, New Mexico, New York, North Carolina, and Ohio) have been awarded funds from the current contract to address the need for school and community health education. Using community action models created during pilot projects, home, school, and community representatives are contacted through statewide task forces to assist in training, program development, and community awareness campaigns as well as implementation of community health education councils, regional conferences, and local workshops. The scope of the new projects includes childhood immunization, sex education, prevention of sexually transmitted diseases, smoking prevention or cessation, nutrition education, and alcohol education. Various States involved in the program have produced community action manuals, established comprehensive health education programs in State schools, implemented inservice training models for professionals, encouraged health systems agencies to incorporate health education into their programs, and obtained revenue-sharing funds from local governments. The CS-CHEP also includes the Student Health Education Forums. These forums involve youth in identifying and making recommendations on health-related matters to organizations that generally do not involve young people in policy and program decisions. The forums give youths throughout the country an opportunity to meet informally and express their concerns on health education issues, such as sexuality, alcohol use, and nutrition.

81P-1128
Health Education Resources Project.
Bowers, M. A.
New Zealand Department of Education, Government Building, Lambton Quay, Private Bag, Wellington, New Zealand
Continuing.

The Health Education Resources Project was implemented to reduce drug and alcohol abuse, promote nonsmoking, provide nutrition education, encourage exercise and aerobic fitness, improve cardiovascular fitness, and promote safety among all New Zealand schoolchildren. The program has 13 component projects including six drug projects, one alcohol project, two smoking projects, one nutrition project, one exercise and fitness project, one cardiovascular health project, and one safety project. The various projects have developed or are developing teaching kits, television spots, booklets, informational folders, guidelines for parents, filmstrips, posters, syllabi, games, role-playing scripts, and other materials for use in health education curricula. Each project has a specific target group, and at least one project is aimed at each student group in forms 1-7. Numerous health-related foundations and organizations and government agencies provide funding for the various components.

81P-1129
ME-ME Drug Prevention Education Program.
Kearney, A.
ME-ME, Inc., 400 South Linwood Avenue, Appleton, WI 54911
Funding Source: Department of Education, Washington, D.C. National Diffusion Network.
1970 - Continuing.

The ME-ME Drug Prevention Education Program is designed to improve the self-concept of students in grades 2-6, enhance their decision-making skills, provide them with information about drugs, and improve their attitudes toward the proper use of drugs. The program, offered by schools in 25 States, provides 1-day training, followup, and awareness sessions for elementary school teachers. The sessions include videotape presentations, lectures, and group activities. Program activities covered during the sessions can be incorporated into many curriculum areas. Schools that participate in the program must promise that their teachers will implement prescribed activities during no less than 30 hours of class time and that they will follow the evaluation requirements outlined for the program. Evaluation instruments include weekly and monthly log reports completed by teachers; self-concept tests for grades 1-6; and separate drug information, attitude, and decision-making tests for grades 2-6. A drug use survey, given before and after intervention, measures drug use behavior of fifth and sixth graders. An early evaluation of the program, which used various instruments to measure decision-making abilities, drug attitudes, and drug knowledge among 935 students who underwent program intervention and 449 control students, indicated that children in the intervention group experienced greater feelings of self-worth, enhanced decision-making skill, significantly increased knowledge levels, and improved attitudes toward drug use. As a result of this study, the U.S. Office of Education has recognized the program as a national model.

81P-1130
Oslo Youth Study.
Tell, G. S. and Vellar, O. D.
University of Oslo, Institute of Hygiene, Gydas vei 8, Oslo 3, Norway
Funding Source: Norwegian Cancer Society, Oslo.

February 1979 - June 1981.

The Oslo Youth Study was initiated in February 1979 to prevent the onset of smoking in 12- to 14-year-old students. Peer leaders, who are 2 to 3 years older than the subjects, are used in the classroom to teach means of resisting peer pressure. The pupils are asked to formally commit themselves to refrain from smoking. A questionnaire concerning health knowledge, attitudes, and habits, including smoking behavior, was used to collect base-line data from the target population in spring 1979, and was administered again in 1981 to evaluate the program. The survey design also includes measurements of serum lipids, hematological parameters, serum thiocyanate, blood pressure, height, weight, skinfold thickness, pubertal development, and indirect oxygen uptake. The base-line survey indicated an average daily smoking frequency of 4.2 percent, ranging from 0.7 percent for boys in the fifth grade (12 years old) to 8.6 percent for girls in the seventh grade (14 years old).

81P-1131
Preschool Health Education Program (PHEP).
Bruhn, J. G. and Parcel, G. S.
University of Texas Medical Branch, Galveston, TX 77550
Funding Source: National Inst. of Child Health and Human Development (DHHS, NIH), Bethesda, Md.
1979 - 1983.

The Preschool Health Education Program (PHEP) is a self-contained curriculum designed to develop positive health and safety behavior in preschool children. Based on a social learning theory of modeling and structured around age-appropriate behaviors, the curriculum has four themes: self-esteem, the body, self-responsibility for health care, and the benefits of good health. The six curriculum units cover self-awareness, physiological functions, physiological needs, factors inimical to good health, behaviors that prevent accidents and disease, and self-care behaviors. Each unit consists of a series of learning activities, which include a statement of purpose, step-by-step procedures, and reinforcement techniques. Two puppets serve as role models, and songs, poems, craft activities, role playing, and finger plays reinforce unit contents. A series of 24 activities has been developed to aid parents in providing educational activities for their children at home. The program assists in the formation of two parent groups and several other parent-involvement events. The parent questionnaire, an inventory of health values and behaviors, is administered each year to the same group of participating mothers. An initial interview is used as a base line from which to assess subsequent changes. At the end of each school year, the participating children, who are 4 years old, are interviewed to assess health locus of control, preferences for health and safety behaviors, and behavioral intentions regarding smoking. In addition, a short questionnaire is administered to the students' kindergarten teachers. Base-line information was collected during 1979 and 1980, and evaluation of the program as it affects a group of children as they grow from 3 to 5 years old will continue until 1983.

81P-1132
Quest.
Charlton, A.
Manchester Regional Committee for Cancer Education, Kinnaird Road, Manchester M20 901, England
Funding Source: Cancer Research Campaign, London (England).
Continuing.

"Quest" is a 135-page cancer education resources pack designed so that high school teachers can incorporate it into other course areas. The program's goal is to dispel myths associated with cancer. The lessons can be integrated into subject matter dealing with biology; general studies; mathematics; French; and environmental, social, or community studies. Pack components include a slide presentation, demographic data related to public health in a medium-sized industrial town, data on cancer incidence throughout the world, interpretation of quantitative data relating to cancer, and a translation exercise from a French-Canadian leaflet. The teacher may choose any or all parts of the pack. A study funded by the Cancer Research Campaign was undertaken to assess knowledge and fears of cancer held by British students and teachers. The findings of this survey provided the background for formation of the resource pack. The target audience consists of children in Great Britain, but the pack is available for international distribution.

SELF-CARE

81-1133
The Self-Care Revolution.
Ferguson, T.
American Pharmacy 20(6):12-15, June 1980.

Interest in self-care has increased rapidly in the last 5 years. The movement places strong emphasis on the role of social support networks, self-help groups, preventive medicine, wellness strategies, and self-care education by

health and medical professionals, particularly pharmacists. The pharmacy is a focal point for self-care, not only through the presence of the pharmacist but also through the accessibility of diagnostic tools. Numerous tests, once available only through medical laboratories, are now provided over the counter. Other services offered by pharmacists include blood pressure screening, health education, distribution of self-care literature, discussion of medication records with patients, establishment of patient health information libraries, dissemination of information on self-care services in the community, sponsorship of self-care courses, educational presentations on local radio and television programs, and participation in local health fairs. Pharmacists can also model self-care behavior. 11 references.

81-1134
Self-Care: A Health Diary Study.
Freer, C. B.
Medical Care 18(8):853-861, August 1980.

A study of self-care practices in a random group of 26 women, 35-44 years old, who kept health diaries for 4 weeks, demonstrated that they practiced self-care on more than 80 percent of the days during which medical problems were present. Symptoms reported in order of frequency included emotional or psychological distress, fatigue, headache, backache, gastric upset, colds, menstruation problems, abdominal pain, sleep irregularities, general aches and pains, leg pains, skin problems, weight fluctuations, heart palpitations, sore mouth, bowel upset, neck pain, arm pain, dizziness, fever, allergy, eye complaints, and genital problems. In addition to self-medication and self-referral to health professionals, relatives, or friends, the women reported many nonmedical actions that were of therapeutic benefit. It seems that self-care, like illness, requires a holistic assessment of the complex interaction of social, psychological, and medical factors.

81-1135
Attitudes Toward Self-Care: A Consumer Study.
Green, K. E. and Moore, S. H.
Medical Care 18(8):872-877, August 1980.

Two hundred and forty-five families, who appeared to be overly dependent on professional medical care and who were enrolled in a prepaid insurance plan in central California were studied to determine (1) the reliability and validity of an attitude instrument designed to assess consumers' attitudes toward self-care and (2) the instrument's sensitivity to group differences. The Linn and Lewis attitude scale, constructed for use with a provider population, was revised and administered by telephone to families who had received interventions through provision of self-care books or through provision of monetary incentives to refrain from use of professional medical care. Families who received no such interventions constituted a control group. Application of factor analysis, one-way analysis of variance, and other statistical analyses to the survey results indicated that (1) the scale had an internal consistency of 0.65 (Cronbach's alpha); (2) five factors had eigenvalues greater than 1.0; and (3) the difference between experimental and control families in mean attitude scores, using perceived health as the independent variable, was not significant. In view of the scale's moderate reliability, it should be revised to provide a more sensitive discrimination of favorable attitudes toward self-care. 9 references.

81-1136
A Nursing Model for the Hospice: Primary and Self-Care Nursing.
Walborn, K. A.
Nursing Clinics of North America 15(1):205-217, March 1980.

The nurse should help ensure that patients under hospice care are provided the opportunity to maintain control over their lives. The hospice nursing system involves collection of social, cultural, religious, health, and psychological data; assessment of the data; formulation and implementation of a self-care plan; and evaluation of the plan's efficacy in relieving the self-care needs of the patient. Special characteristics that allow primary care nurses to implement a self-care model in a hospice include acceptance of the patient-family concept, effective functioning as a member of a multidisciplinary team, and recognition of others' needs as separate from one's own. The practice of primary nursing provides opportunities for provision of individualized care, continuity and consistency in nursing care within the patient care group, detailed knowledge about a group of patients versus superficial knowledge about all patients, and professional autonomy through the increased responsibility of planning and evaluation for all patients. The general goals of hospice care for the patients include control of physical symptoms; reduction of the sense of isolation; maintenance and control of decisions that influence treatments, care provided, and lifestyle preferences; and continued contact with families during the bereavement period. 5 references.

81P-1137
Health Activation Program.
Cohen, M. S.
Southern Illinois University at Carbondale, Student Wellness Resource Center, Kesnar Hall, Carbondale, IL 62901
1978 - Continuing.

The Health Activation Program (HAP) of the Student Wellness Resource Center at Southern Illinois University at Carbondale was established to provide information and support to students interested in taking greater responsibility for their health. Services include (1) a self-care resource room containing pamphlets, displays, and a lending library; (2) individual consultation for students seeking self-care information; (3) the Cold Comfort Center, providing self-assessment and self-care information for upper respiratory problems; (4) educational programs on self-care topics such as massage and women's health and nutrition; (5) a 4-week self-care course offered each semester; (6) the Student Wellness Outreach Program located in a residence hall and staffed by a nurse who is available to discuss students' health concerns, encourage self-treatment, and refer students to campus resources; (7) and a telephone health message system, which provides self-care information on common ailments, stress reduction techniques, and self-care resources located on campus. The program provides training opportunities for both graduate and undergraduate field placement, practicum, and internship students. Extensive use is made of the daily university newspaper and local radio stations to disseminate self-care information. The Student Wellness Resource Center serves a student population of 22,000. HAP maintains a contract with Synergy, a nonprofit community agency, to provide peer counseling.

81P-1138
Osteogenesis Imperfecta Foundation, Inc.
Geisman, G. 632 Center Street, Van Wert, OH 45891
1970 - Continuing.

The Osteogenesis Imperfecta Foundation was founded in April 1970 to enable parents of children affected with the disease (a genetic disorder characterized by extreme fragility of the bone) to share experiences and resolve mutual problems. The foundation, which is a private, nonprofit, self-help organization, disseminates information to afflicted families, physicians, and the public through brochures, articles, and a quarterly newsletter. A board of directors consisting mainly of parents and patients determines the policies of the organization. A medical advisory board advises directors on means of coping with the disease.

SEX EDUCATION

81-1139
A Principles Approach in Family Life Education.
Burr, W. R.; Jensen, M. R.; and Brady, L. G.
Family Coordinator 26(3):225-233, July 1977.

Recent developments in family life education have given rise to a principles approach to the subject matter. The principles approach emphasizes a set of three learning objectives or educational outcomes, namely, learning general principles, learning how to apply principles in specific situations, and learning skills to implement the principles in everyday life. The facilitating developments that allowed the emergence of the approach included publication of a large body of literature on the development and refinement of theories, improvement in the quality of theories about the family, improvement in the methodology of bridging research and practice, and movement by social scientists away from basic research and toward emphasis on practical policy development. Principles (1) contain two or more variables or factors, (2) contain a statement about how the two variables are related, (3) are law-like, (4) are sufficiently general or abstract to be relevant in a wide variety of specific situations, and (5) are universal. The principles approach is efficient, allows for value differences, provides information on consequences, bridges the gap between intellect and behavior, teaches a mode of organizing information, stimulates research, and allows itself to be adopted by many educational fields. The approach is limited by its inability to help students discover certain values, its deemphasis on descriptions of changes, its demanding intellectual requirements, and the tentative nature of social science principles.

81-1140
Build Sex Education Programs Without Tearing Apart the Community.
Thompson, M.
American School Board Journal 166(7):28-30, July 1979.

Guidelines for introducing sex education programming into schools at the local level are provided. Prior to initiation of a program, planners should determine parental needs and desires, allow 1 to 3 years for planning, formulate a detailed statement of program goals and activities, screen and train teaching staff with great care, and refrain from fostering unreasonable expectations about the program. The program should be optional and should be taught by instructors who are comfortable with their sexuality. General information, curriculum materials, and advice on the means of developing a program can be

obtained from the American Association of Health, Physical Education, and Recreation; the American Association of Sex Educators, Counselors, and Therapists; the American Institute of Family Relations; and the Sex Information and Education Council of the United States.

81-1141
Waging War on V.D.
Yarber, W. L.
Science Teacher 45(5):38-42, May 1978.

While advances have been made in diagnosing and curing sexually transmitted diseases (STD), controlling their spread is still a major problem among young people. Teachers can contribute to curbing the problem by informing students about STD, encouraging them to adopt mature attitudes and preventive measures, and telling them where to seek treatment. When approaching STD education, teachers should (1) involve parents, school officials, and students; (2) introduce the curriculum in middle or junior high school; (3) introduce the material in a unit on communicable diseases rather than as part of sex education; (4) concentrate on the most pertinent aspects of the problem without overwhelming the students; (5) restructure attitudes toward STD to avoid stigmatizing affected persons; (6) promote discriminating sexual behavior and social responsibility among persons who have contracted STD; and (7) use student-centered learning activities, such as role playing, values clarification, case studies, and problem solving. A sample quiz, a list of STD learning resources (books, pamphlets, multimedia, and organizations), and a summary of important information related to STD are included. 16 references.

81P-1142
Human Sexuality Service (HSS).
Cohen, M. S.
Southern Illinois University at Carbondale, Student Wellness Resource Center, Kesnar Hall, Carbondale, IL 62901
Continuing.

The Human Sexuality Service (HSS) of the Student Wellness Resource Center at Southern Illinois University at Carbondale was established to provide a supportive, nonjudgmental environment to help 22,000 students explore and clarify their own sexual feelings, needs, and concerns. Services include (1) individual counseling for (a) unplanned pregnancy, (b) birth control, (c) sexual dissatisfaction, (d) gay sexuality, (e) sexual functioning, and (f) relationship issues; (2) educational programs, including special presentations in the student center, residence halls, and classrooms on a wide range of sexual issues and concerns; (3) continuing group sessions on birth control, sexual awareness, and gay support; (4) special weekend workshops on sexual awareness and enrichment, male and female sexuality, lesbian sexuality, and sexual awareness for professionals; (5) a small library of resource materials on sexuality; (6) a referral service for persons making inquiries about abortions, sexually transmitted diseases, and long-term counseling; and (7) distribution of free pamphlets on birth control and venereal disease. Students may also receive training in pregnancy counseling, sexual counseling, birth control counseling and leadership, and facilitation skills for small groups and workshop programs. HSS is an approved site for practicum, internship, field placement, and graduate assistantship training. A contract is maintained with Synergy, a nonprofit community agency, to provide peer counseling and crisis intervention services. Data on consumer satisfaction are gathered and tabulated for individual counseling, group counseling, workshop sessions, and weekend sessions. In addition, outcome evaluations have been conducted on the residence-hall birth control programs and sexual awareness weekends. More outcome evaluations are in progress.

81P-1143
Program to Expand Sexuality Education in Cooperation With Youth Serving Agencies.
Quinn, J.
Center for Population Options, 2031 Florida Avenue, N.W., Washington, DC 20009
July 1977 - December 1981.

The "Program to Expand Sexuality Education in Cooperation With Youth Serving Agencies" was developed in cooperation with 20 national youth-service agencies to reduce the high incidence of adolescent pregnancy. The program helps national youth-serving organizations develop and implement sex education policies and programs. The center and cooperating agencies introduce sex education into schools and improve birth control services for teens. Program staff work with youth-service agencies to (1) assess the need for sex education among their members, (2) provide organizational training for agency staff at national and community levels to facilitate program implementation, (3) produce usable materials for national and community program activities, (4) develop communitywide activities in selected model cities, (5) develop model projects appropriate to a variety of organizations and localities, and (6) generate public concern for the problems associated with adolescent pregnancy and encourage the introduction of sex education and birth control services at the community level. The program is staffed by a director, a project associate, and a project assistant. Youth workers in Cleveland, Des Moines, and Seattle received intensive training in 1978 and followup consultation services from 1978 through mid-1980. Funding is derived from several foundations and trusts.

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INTRODUCTION

Current Awareness in Health Education (CAHE) is published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents acquired and selected by the Center. CAHE also contains descriptions of programs in health education. These descriptions are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources. To make the information in CAHE timely, only documents published or programs of relevance since 1977 are included.

Copies of each document and supporting documentation for each program description are stored in the Center's permanent collection. Users of CAHE are urged to consult local public, medical, and university libraries for individual copies. Sufficient information is provided in the citations to enable users to locate copies or to contact programs.

All persons receiving CAHE are invited to contribute copies of pertinent documents and descriptions of relevant programs for possible inclusion. The Center also welcomes any comments on CAHE and suggestions to improve its usefulness. Write or call:

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CAHE contains two types of records: informative abstracts of published literature and descriptions of ongoing programs. These records are arranged in chapters according to their major subject area. Chapter headings are used to group items generally related and include: Community Health Education; Health Education in Occupational Settings; Health Education Methodology; Patient Education; Professional Education and Training; Regulation, Legislation, and Administration; Research and Evaluation; Risk Reduction; School Health Education; Self-Care; and Sex Education. The chapter headings reflect active areas in health education as well as major interests of the Center for Health Promotion and Education. To locate specific items of interest, users are encouraged to use the extensive Subject, Author, and Program Title indexes found in the back of each issue.

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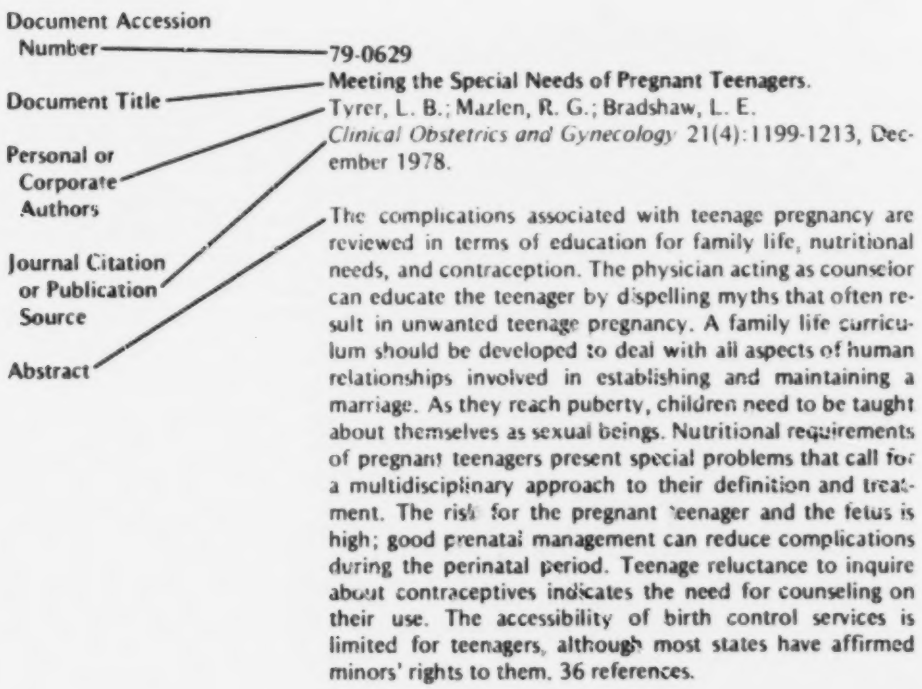
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Clinical Obstetrics and Gynecology 21(4):1199-1213, December 1978.
Abstract
The complications associated with teenage pregnancy are reviewed in terms of education for family life, nutritional needs, and contraception. The physician acting as counselor can educate the teenager by dispelling myths that often result in unwanted teenage pregnancy. A family life curriculum should be developed to deal with all aspects of human relationships involved in establishing and maintaining a marriage. As they reach puberty, children need to be taught about themselves as sexual beings. Nutritional requirements of pregnant teenagers present special problems that call for a multidisciplinary approach to their definition and treatment. The risk for the pregnant teenager and the fetus is high; good prenatal management can reduce complications during the perinatal period. Teenage reluctance to inquire about contraceptives indicates the need for counseling on their use. The accessibility of birth control services is limited for teenagers, although most states have affirmed minors' rights to them. 36 references.

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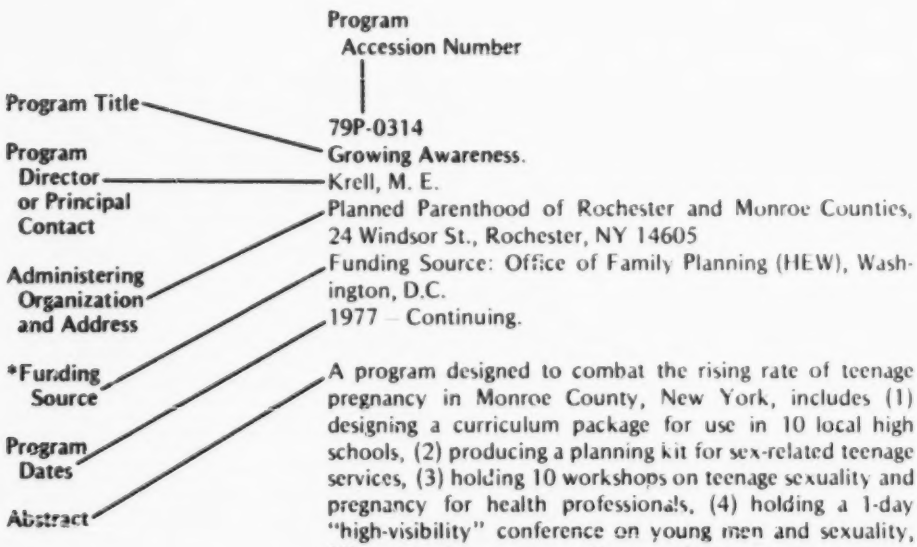
Each program description is uniformly identified and described by the elements labeled in the sample below:


Program Accession Number
Program Title
Program Director or Principal Contact
Administering Organization and Address
*Funding Source
Program Dates
Abstract
79P-0314
Growing Awareness.
Krell, M. E.
Planned Parenthood of Rochester and Monroe Counties, 24 Windsor St., Rochester, NY 14605
Funding Source: Office of Family Planning (HEW), Washington, D.C.
1977 – Continuing.
A program designed to combat the rising rate of teenage pregnancy in Monroe County, New York, includes (1) designing a curriculum package for use in 10 local high schools, (2) producing a planning kit for sex-related teenage services, (3) holding 10 workshops on teenage sexuality and pregnancy for health professionals, (4) holding a 1-day "high-visibility" conference on young men and sexuality, (5) conducting a mass media campaign to attract teenagers, and (6) establishing a hotline. An Adult Advisory Group and a Teenage Advisory and Reaction Group participate in the program.

CAHE contains three indexes. They are: (1) Author, which contains the names of personal and corporate authors of documents and directors of programs; (2) Subject, which contains subject descriptors, including geographic location, for both documents and programs; and (3) Program Title, which contains names of programs that are either mentioned in documents or detailed in program descriptions.

*The funding source is specified if the program receives funds from institutions other than the administering organization.

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PROGRAM DATA SHEET

The Center for Health Promotion and Education is collecting information about current health education programs for use in *Current Awareness in Health Education* and in analyzing program trends in the field. A program may provide identification, public awareness, coordination, training, demonstration, etc.

If you wish to share your program efforts with other health education professionals, please complete the form below, being as specific as possible in providing information.

We greatly appreciate your taking the time to share your experience with us.

---

1. Program Identification:

   Official Title of Program or Grant and Grant No: _____

   Official Name of the Organization Conducting the Program: _____

   _____

   Address of the Organization:

   _____
   street city state zip code

   Program Director: _____
   name title telephone area code number

   Principal Contact: _____
   (if different from Program Director) name title telephone area code number

   Beginning Date of Program: _____ Ending Date, If known: _____

2. Funding Source for Your Program:

   Please provide the Name(s) and Location(s) (City, State) of Funding Source(s):

   _____

   _____

   _____

3. Focus of Program: _____Administration _____Community Health Education _____Health Education Methodology

   _____Nutrition Education _____Occupational Health Education _____Patient Education

   _____Professional Training Programs _____Research and Evaluation _____Risk Reduction _____Sex Education

   _____School Health Education Other _____

4. Target Population(s): _____

5. Purpose of Program: Please describe the primary purpose of your program

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Publications/Information Materials: Please send copies of any publications or material describing your program, if available, or give complete citation (author, title, date, publisher). If no publications exist or are planned, please state how further information may be obtained.

   _____

   _____

   _____

   _____

   _____

THANK YOU.

(PLEASE CUT ALONG DOTTED LINE)

BEST DOCUMENT AVAILABLE

Name, Title of Person Submitting Program Information

Organization

Street

City, State, Zip Code

Phone

Fold Here First

Place stamp here

Centers for Disease Control
Center for Health Promotion and Education
ATTN: Current Awareness in Health Education
Atlanta, GA 30333

Fold Here

(PLEASE CUT ALONG DOTTED LINE)

Staple or Tape

COMMUNITY HEALTH EDUCATION

81-1144
A New Breed of Consumer Advocate Asks Physicians to Help Her "Set the Record Straight."
Legal Aspects of Medical Practice 8(8):20-21, August 1980.

Physicians should become more involved in debunking myths generated by the consumer movement, particularly misconceptions in the area of nutrition, on both the physician-patient and public levels. An example of such activity is the American Council on Science and Health, a group of 20 physicians who provide consumer education and who correct statements in the press that are inconsistent with reports from the scientific community. The council combats consumer movements that, while achieving few positive ends, have increased the cost of of patient care by increasing government regulatory activity. The council publishes a bimonthly newsletter and performs other public education and advocacy services. Although the group's attention so far has been limited to the use of pesticides, food additives, and air pollution, the focus will eventually turn to other issues of more immediate interest to practicing physicians.

81-1145
Wellness Promotion: A Proposed Focus for Regional Planning in Canada (Editorial).
Ardell, D. B.; Leister, D. W.; and Martin, S. M.
Canadian Journal of Public Health (Ottawa) 71(5):299-301, September-October 1980.

The Lalonde report ("A New Perspective on the Health of Canadians") and similar works in recent years have increased public awareness of the influence of lifestyle on health and have increased demands for a regional focus on health planning in Canada. Such a focus requires the creation of "responsibility centers" to provide a stimulus for health promotion at the community level. Quebec and Ontario have implemented regional systems: Quebec has developed professionally oriented local planning councils for health and social services, and Ontario has established volunteer-oriented health planning bodies. Regional planning bodies facilitate coordination of components of the health system, enhance rationalization of resources and the identification of medical treatment needs, and place needed emphasis on health promotion. These regional planning bodies are able to relate to many public, quasi-public, and private jurisdictions concerned with health and to take advantage of the populist nature of wellness promotion. Further efforts by regional centers should include developing programs that raise community consciousness regarding health problems and lifestyle improvement, developing program models for use by various community organizations, negotiating roles and responsibilities for local agencies, and implementing demonstration projects. 2 references.

81-1146
Traveling Service Agency Promotes Health Maintenance.
Brin, D. and Granville, J.
Hospital Progress 61(6):66-67, 80, June 1980.

The Professional Health Resource Center (PHRC), a private, nonprofit traveling health service agency, provides a target population of approximately 30,000 adults 60 to 75 years old living in 7 northwest Georgia counties with monthly audiovisual and lecture programs devoted to health maintenance. PHRC staff visit 8 sites within a 70-mile radius, conducting educational programs on blood circulation, foot care, physical activity, nutrition, medication, common symptoms of illness, and relief of loneliness. A goal-setting model helps participants assume responsibility for their health after attending PHRC presentations. Initially funded by a religious order, PHRC now obtains most of its funding from the Appalachian Regional Commission (ARC) and the Tennessee Valley Authority and is considering charging fees to clients and third-party payers. Each PHRC presentation lasts approximately 40 minutes and offers information from a consultant, such as a nurse, podiatrist, nutritionist, or physician, followed by a discussion session. An evaluator for the ARC is assisting PHRC in assessing its programs based on testing with an internal locus-of-control scale.

81-1147
Decisions and Drinking: A National Prevention Education Strategy. Proceeding of a Workshop.
Davis, C.
Arlington, Va., National Center for Alcohol Education 102 p., January 22, 1978.
Available from: ERIC, Order No. ED-173741.

Training materials are presented for use in a national prevention education program designed to develop community awareness of personal decisions leading to

reduced drinking problems and alcoholism. Prevention education materials for women, parents of young children, and black Americans are provided. The workshop materials encourage participants to develop individual plans to be used in their own States. A new strategy has been developed and incorporated into the materials to enable planners to reach local communities and use community members as group leaders. A discussion of recommended target audiences for each workshop program is appended.

81-1148
Eyes Right for Glaucoma Detection.
Downing, L.
Volunteer Leader 21(1):10-12, Spring 1980.

In 1978, the auxiliary of the Mercy Medical Center of Oshkosh, Wisconsin, began to implement a glaucoma education and screening program. Following guidelines in a manual from the National Society to Prevent Blindness (NSPB), a steering committee was established that included ophthalmologists, optometrists, county nurses and representatives from the hospital, a visiting nurse association, the city health department, Red Cross, Lions Club, and Oshkosh Senior Center. Through the efforts of committee members, the program provided funding for purchases of educational materials and provision of financial assistance to glaucoma patients, viewed NSPB films for possible use in public education efforts, determined which screening volunteers would be covered by the hospital's insurance, and informed all local medical personnel about the program. During the program's first month, auxiliary and Red Cross volunteers screened hospital employees and held a health fair. Continuing volunteer training is done by staff of the Wisconsin Society for the Prevention of Blindness and ophthalmic assistants. Patients referred for ophthalmic examination are contacted if they do not see an ophthalmologist within 2 months. Evaluations of the program, done at monthly meetings of the steering committee, have indicated that the program has been successful.

81-1149
Hypothermia in the Elderly: The Health Education Council's "Cold Kills the Old" Campaign.
Health Education Council, London (England). Medical and Research Div.
Health Education Journal (London) 36(2):49-54, 1977.

In response to research estimates that 500,000 elderly people might be at risk for hypothermia, the Health Education Council in England and Wales mounted a multimedia campaign between December 15, 1976, and January 15, 1977. The campaign included broadcast of television spots and distribution of posters and booklets to inform the elderly and those caring for them of the problem. Copies of the booklet were distributed to 1,800 clubs that participated in the National Federation of Old Age Pensions Associations. Program evaluation consisted of interviews in the homes of 1,000 adults representative of the populations of England and Wales. Interview data indicated that (1) the proportion of persons indicating that hypothermia was a major problem among the elderly increased from 65 percent before the campaign to 80 percent after the campaign; (2) the proportion of people who checked on the condition of elderly persons in their area increased from 34 percent to 42 percent; and (3) general awareness of the plight of the elderly increased significantly. 4 references.

81-1150
Public Education About Cancer: Recent Research and Current Programmes.
Hobbs, P., ed.
Geneva, Switzerland, International Union Against Cancer. UICC Technical Report Series--Volume 45., 104 p., 1979.

Recent research and current projects in public education about cancer are reviewed in an anthology of papers from eight countries. Topics include methods of cancer prevention and control requiring community action; a survey of opinions and attitudes on cancer among some high school children in Singapore; development and evaluation of Quest, a multidisciplinary cancer education resources package for schools; prevention of the onset of smoking; evaluation of the educational program in the fight against nicotine addiction in France; attitudes and smoking habits of doctors in Victoria, Australia; means of involving doctors in health education about cancer; an analysis of U.S. newspaper coverage of cancer; the extent of the American public's knowledge of cancer and cancer tests; motivation factors that affect participation by West Germans in cancer screening programs; activities of the Industrial Cancer Education Service of the Ontario division of the Canadian Cancer Society; delivering health education to people at work in Manchester, England; and means of launching long- and short-term industrial education programs in Manchester, England.

81-1151
Assessing Rural Health Education Programmes in Rhodesia.
Mooney, M.
International Journal of Health Education (Geneva) 22(4):249-252, 1979.

A study of 50 health assistants who implement rural health education programs in the Manicaland Province of eastern Rhodesia was designed to provide an understanding of the factors involved in successful programs. The health assistants were asked to write two short essays, one on their most successful program and one on their least successful program. Analysis of the essays indicated that the factors associated with successful programs, in order of importance, were educational activities, consideration of the target audience's perceived needs, discussion with the Kraal head, discussion with the chief, cooperation of the headmaster, help from the local council, involvement of influential persons, provision of refreshments, implementation of the program at a convenient time, and provision of a ceremony upon program completion. Factors identified as contributing to program failure, in order of importance, were lack of health education; shortage of money; lack of cooperation in the community; use of force by health educators; opposition from the community; exclusion of influential people from the program; lack of planning; political opposition; the prevalence of traditional beliefs; community suspicion; interference by community advisers; certain religious beliefs; and a lack of time, material, personnel, or followup. A rural program model for health extension workers is provided. 3 references.

81-1152
Computer Games for Teaching Nutrition.
O'Hayan, C.; Altosaar, I.; Nantel, G.; and Armstrong, J.
Journal of Nutrition Education 12(4):190, October-December 1980.

In response to requests to participate in health fairs or nutrition information functions, the Nutrition and Dietetics Program at the University of Ottawa in Ontario, Canada, developed three computer programs that teach nutrition topics by utilizing participatory games. Two games address the needs of adolescents and senior citizens and the other promotes nutritional snacks. The programs have proved successful in stimulating public awareness.

81-1153
Scholars Who Teach.
Seitz, R.
World Health (Geneva) p. 22-27, August 1979.

Since 1977, when the Philippines introduced the Barangay Nutrition and Health Scholars to bring sensible eating habits to the preschool children of small, low income communities, the proportion of extremely malnourished children has decreased by 38.5 percent. Each barangay, which is the smallest local administrative unit in the country, is assigned a scholar who provides nutritious food to malnourished children and provides nutrition education and promotion services to village families. The scholars also refer severely malnourished children to provincial hospitals.

81-1154
General Comments on Health Education Planning Actions in AIPs (Annual Implementation Plans) of New England HSAs (Health Systems Agencies).
Simmons, J. J.
Boston, Mass., Boston University, Center for Health Planning, 5 p., 1979.
Available from: NTIS; Order No. HRP-0029856.

An examination of health education planning actions in the annual implementation plans of health systems agencies (HSA's) in New England indicates that many plans do not address the means by which the general public is to be educated about concerns and interests of the HSA's. Moreover, the plans do not interpret the nature of health planning and the means by which HSA's should develop plans to improve health status, health resources, and the effective use of health services. The effectiveness of a public information and education program can be determined by identifying information about HSA activities; planning for regular dissemination of information about specific goals, objectives, activities, and progress to persons other than those actively involved in the HSA structure; establishing mechanisms for feedback from all resources; and developing systematic means of monitoring information dissemination, use, and feedback. Although annual implementation plans have extensive mortality and morbidity data for their areas, they frequently do not have utilization data for health services. Key points to be included in a screening program are means of detection, referral to care, selection of appropriate therapy and surveillance, and long-term maintenance of therapy. Population concerns and behaviors should be analyzed in decision making about health education planning.

81-1155
Mastectomy Counseling for Men.
Simmons, R. P.
In: National Cancer Inst.: Fourth National Cancer Communication Conference--Proceedings. Chicago, Ill., June 1977. Bethesda, Md., the Inst. (DHEW Publication No. (NIH)78-1463), p. 135-139, 1978.

A small self-help group in Santa Clara County, California, has been formed to provide counseling to husbands and

male friends of women who have undergone mastectomies. One of the leading functions of the counselors, who are husbands of women who have had mastectomies, is to correct misconceptions concerning the physical and sexual condition of women who have undergone mastectomies. A recent evaluation of the program indicated that it has been well received. The provision of individual counseling and the quick referral-response time were found to be particularly important to the program's success.

81P-1156
Blue Cross of Northeast Ohio Drug Education Program.
Noll, J.
Blue Cross of Northeast Ohio, 2066 East 9th Street, Cleveland, OH 44115
February 1980 - Continuing.

The Blue Cross of Northeast Ohio Drug Education Program was designed to make children aware that drugs are harmful if abused and to convince children to lead active lifestyles. Presentations that include films are made to elementary school children. A story booklet that parallels the film is distributed to the children, who are instructed to take the booklet home to their parents to aid in discussion of drug abuse. The children are also given coloring books designed to demonstrate that exercise, good nutrition, and other beneficial lifestyles are preferable to drug use. Parents receive a letter that explains the program and their part in it. Presentations have been made to over 800 children in over 14 schools throughout northeastern Ohio since the program's inception in February 1980.

81P-1157
Breast Self-Examination Class.
Dorsay, R. H.
Kaiser Permanente Hospital, Department of Radiology, 1200 El Camino Real, South San Francisco, CA 94080
February 1978 - Continuing.

The breast self-examination (BSE) class offered by the Kaiser Permanente Medical Group of South San Francisco, promotes BSE and teaches women to perform this procedure. The monthly class, which usually consists of 15 to 25 women, lasts 90 to 120 minutes. Participants are given a booklet on breast lumps, a pamphlet on BSE, and a 10-question self-help quiz before beginning class. The pamphlet and quiz were designed by the American Cancer Society (ACS). Class activities include a short lecture, an ACS film on BSE, BSE demonstrations, a review of the self-help quiz, a lengthy question-and-answer period, and a commitment by each woman to examine her breasts monthly. Each participant is sent a reminder to continue BSE 4 and 12 months after the class. The reminder includes a short form that allows the women to indicate whether they are performing BSE regularly and, if not, the reasons that they have ceased. The program is run by a physician who is the chief of the Department of Radiology at Kaiser Permanente Hospital in San Francisco.

81P-1158
Community Development and Basic Health Care Service in Rural Villages of Northern Thailand.
Archibald, H. D.
Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, M5S 2S1, Canada
Funding Source: Canadian International Development Agency, Hull.
September 1, 1980 - December 1, 1982.

The Community Development and Basic Health Care Service in Rural Villages of Northern Thailand was designed to (1) assess health and related social and community problems in rural communities, (2) develop a basic health care model for the area that will parallel agricultural improvement projects, and (3) develop a training program for village health workers to enable them to undertake basic health care delivery and public health education programs. These objectives will be achieved by (1) conducting a health examination of all the inhabitants of 33 villages that participate in this development project each year for 3 years, (2) studying the interrelationships between health and socioeconomic problems in the villages, (3) selecting and training indigenous village health workers, (4) constructing a health station in each village, and (5) supplying each village with a health kit that contains contemporary medicines to combat regional diseases. The 7,000 villagers that live in the 33 villages in this "Golden Triangle" region constitute the target audience. The work plan was developed by a World Health Organization consultant in conjunction with the staff of the Institute of Health Research at Chulalongkorn University in Bangkok. Health and demographic surveys will be implemented before and after the 3-year program to assess the intervention strategies.

81P-1159
Health Awareness in Underserved Communities.
Student National Medical Association, Inc., 2109 E Street, N.W., Washington, DC 20037
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1975 - June 1978.

"Health Awareness in Underserved Communities" was a program to develop, implement, and test health education awareness activities that emphasize cancer prevention in communities where inadequate health information and lack of good health practices exacerbate problems of health personnel shortages and insufficient health facilities. The Student National Medical Association (SNMA), the administering organization, focused on the role of the nonwhite health professional as a model and health leader. Specific program activities were to include establishing a 10-member advisory board, consisting of SNMA members and American Association of Medical College members, including at least one Chicano or native American. This board was to meet four times to provide advice to SNMA staff and chapters. Program activities also included soliciting and evaluating proposals from the 10 SNMA regions for model projects that are replicable; selecting and implementing at least six of the submitted proposals for model projects; developing means of evaluating the overall project and its constituent components; working with government and private health personnel training channels to develop the role model concept; developing means to incorporate more effective role awareness and leadership motivation in health education practices of the National Medical Preceptorship Program; publishing articles on the program in SNMA publications; and sponsoring a 2-day national health education planning and information exchange conference involving key project participants from each of the SNMA regional sectors. The SNMA was to submit copies of guidelines for material development and dissemination, plans for soliciting and selecting regional model projects, a roster of advisory board members, regional model project proposals, plans for development of the model health personnel education and training program, conference plans, quarterly progress reports, and a final progress report.

81P-1160
Health Education for Handicapped Children in Four Texas Communities.
University of Texas Health Science Center at Houston, P.O. Box 20036, Houston, TX 77025
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1975 - March 1978.

The Health Education for Handicapped Children in Four Texas Communities program was to develop, implement, and evaluate health education programs for handicapped children. The Health Science Center of the University of Texas at Houston, the administering organization, targeted Mexican American, migrant, rural, and urban Texas communities. Eligible children were those with more than one handicap. After developing detailed descriptions of each community, two educational specialists were to be selected from each community for extensive training in health education techniques. Three 1-week training seminars were to be developed and provided to the selected specialists. The individualized seminars were accompanied by development of instructional packets and specific modules on decision making, problem solving, child management, and prevention designed to help families confront health issues. The Health Science Center was required to develop a special media and materials program for the selected communities. At least three visits were to be made by center staff to each community, and special consultations by center staff were to be provided to ensure provision of ongoing technical assistance. A 2-day conference for administrators and directors of Mexican American health programs was to be held to develop health education models. Behavioral changes in parents and children served by trained specialists were monitored and evaluated against specified objectives. Periodic progress reports, a plan and methodology for development and implementation of programming for the handicapped children and their parents, and a final report were to be submitted by the Health Science Center.

81P-1161
Health Education Through Community Health Representatives.
New Mexico Health Education Coalition, 816 Broadway, S. E., Albuquerque, NM 87102
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1975 - October 1978.

The Health Education Through Community Health Representatives program was to develop three models that demonstrate the advantages of providing health education services to three target groups (rural, Hispanic, and native American) through their designated community health representatives. The community health representatives trained during the program were to include herbal medicine men, midwives, and other traditional healers. The model for each community identified key community health representatives, outlined knowledge and methods used by representatives, provided plans to improve and expand the knowledge and skills of representatives, identified professionals who are experienced in folk medicine and indigenous health practices, included plans and schedules for training sessions, and diagnosed community leadership patterns and communication networks. Using the models as guidelines, the Health Education Coalition was to facilitate workshops, seminars, and other educational interventions; explore the possibility of using in-

novative interventions and cooperative extension service programs to reach specific target groups; identify customs that influence health and disease problems; develop and test prototype resources for educating target group members; and employ out-of-State consultants to work with disadvantaged and isolated groups. Each stage of the coalition's intervention was to be documented by reports, and a final report was submitted to summarize the project.

81P-1162
New England States Heath Education Program.
University of New Hampshire, School of Health Studies, Durham, NH 03824
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
May 1975 - October 1978.

The New England States Health Education Program was designed to develop a health education strategy for the New England States, with special attention given to heart disease and cancer. The School of Health Studies of the University of New Hampshire (the administering organization) at Durham used the expertise of the Boston Regional Office of the Department of Health, Education, and Welfare (HEW), State health departments, universities, voluntary agencies, and health consumer organizations. Specifically, the School of Health Studies contracted to establish a planning committee of representatives from each of the six New England States to design the plan, serve as an advisory group for a regionwide health education conference, and serve as contact points in their respective States. The school was also to conduct a conference for at least 80 health and educational leaders; work with at least five agencies and institutions in the region that are able to conduct quality control demonstration or model health education activities; provide technical assistance and consultation to organizations that wish to implement or reorganize health education endeavors; identify means by which HEW staff can more effectively meet health education needs of patients; and develop the health education plan, outlining specific methods, techniques, and approaches. Project staff were to submit (1) reports at 3-month intervals, (2) a copy of the proceedings of the conference, (3) a copy of the plan, and (4) a final project report.

81P-1163
Peer Support System.
Chenoweth, B.
University of Michigan, University Hospital, Turner Geriatric Clinic, 1010 Wall Street, Ann Arbor, MI 48109
Funding Source: Administration on Aging (DHHS), Washington, D. C.
1978 - Continuing.

The peer support system of the Turner Geriatric Clinic of the University of Michigan Hospital at Ann Arbor provides health education and social support for outpatients 60 years old and older. The system provides mental health services, health education, and community services for the elderly by recruiting and training peer counselors and conducting monthly health education workshops. The peer counselors and the elderly form social support networks that help them cope with their problems. The counselors also design and implement workshops at four sites on topics of interest to the elderly. Information is distributed at workshops, and publicized by radio stations, senior citizen newsletters, church bulletins, and newspapers. Peer counselors also speak to audiences at senior citizen housing projects, senior centers, and churches and visit fellow seniors at home. Small discussion groups deal with specific problems identified at workshops. Older persons living in Ann Arbor, Saline, Ypsilanti, and the Chelsea Retirement Home are served. Program staff other than the 48 peer counselors include a social worker and two peer coordinators at each site. Program consultants include a physician, psychiatrist, nurse clinician, dietitian, and other hospital personnel. The workshops are evaluated with short forms administered to participants, telephone interviews of selected participants, and written and recorded evaluations by peer counselors. Results of the evaluations suggest that the workshops were valuable in providing practical information, relieving anxiety, changing bad habits, and offering emotional support.

81P-1164
Rural Health Education Project.
Tuskegee Area Health Education Center, Inc., Bldg. No. 9, VA Hospital, Tuskegee, AL 36083
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1975 - October 1978.

The Rural Health Education Project was designed to meet the health care needs of rural target groups. The Tuskegee Area Health Education Center, of Tuskegee, Alabama, the administering organization, was to develop and test a series of prototype health education programs through work with staff and representatives of an interdisciplinary consortium of institutions, agencies, and organizations. Specifically, the institute contracted to evaluate the health education services provided by each consortium member; determine the needs of consortium members, consumer groups, and individuals served by members; develop and test guidelines, prepare sequential objectives, and delineate material resource requirements for improvement of existing and provision of new health education services; maintain an advisory council, comprised

of consortium members and representatives from consumer groups and organizations; provide technical assistance and other support to consortium members for developing and testing their health education programs; monitor the development of each prototype health education program; direct special attention to veterans under secondary and long-term care, patients at rural health care centers, neighborhood and community leaders, and families that receive public assistance; explore possibilities for developing sequential health education curricula for primary school children in at least one school district; integrate new health education programs with existing programs; and facilitate liaisons among consortium members. The institute was to submit periodic progress reports, copies of procedures used to document health education activities of consortium members; copies of prototype health education programs; a report on plans for introducing the project to other consortium centers in the country; and a draft and final version of a report on the overall programming and results of programming.

81P-1165
San Andreas Health Council.
Myerson, B. 531-541 Cowper Street, Palo Alto, CA 94301
June 1974 - Continuing.

The San Andreas Health Council provides holistic education and clinic services for the community. The council offers individual and group counseling services, experiential classes, biofeedback courses, groups for the elderly, a center for counseling acutely ill persons, a massage group, an Aston patterning group, an acupuncture group, medical treatment, chiropractic treatment, nutrition counseling and therapy, movement therapy, physical therapy, and other related services. Though the program primarily reaches an audience of several thousand people on the San Francisco peninsula, there are no geographic limits to those served. Council staff includes 31 professionals from medical, social work, counseling, and physical therapy disciplines. The council coordinates with other educational programs and institutions and consistently seeks means of developing more joint programs. Evaluations are done primarily by the students at the end of the classes. A new format for evaluation and new evaluation criteria are being formulated.

81P-1166
San Diego County Medical Society Health Education Programs.
San Diego County Medical Society, Inc., 3702 Ruffin Road, P.O. Box 23015, San Diego, CA 92123
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
February 1975 - April 1976.

The San Diego County (California) Medical Society Health Education Programs were designed to provide audiotapes of medical and health information for consumers on high-priority topics, provide guidelines and technical assistance to promote and evaluate lay consumer use of health resources, provide guidelines for replication of selected model health education activities, and provide assistance to other organizations in these areas. Specifically, the medical society was to maintain an interagency council on health education with representatives from local health and educational organizations to oversee the project; organize local community health and education resources to provide necessary guidelines, consultations, site visits, and accountability services to at least three other metropolitan areas of the country; develop, test, evaluate, and promote professional and consumer use of Tel-Med tapes dealing with cancer, heart and lung disease, and other preventable diseases; prepare guidelines on health education approaches for specialized populations on priority health matters; and develop and evaluate smoking education and control measures within the local community. Programming in the three other metropolitan areas was to emphasize community health education organization, Tel-Med development, peer training and Tel-Med tapes designed for schoolchildren, and industrial health education programs, including peer education and Tel-Med programs. Specialized populations for which health education guidelines were to be developed include minorities and workers in occupational settings.

81P-1167
State Government Health Education Management Model.
State of Florida Department of Education, 106 Center Building, Tallahassee, FL 32304
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1976 - September 1979.

The State Government Health Education Management Model was designed to develop and evaluate an official State agency health education managerial model for coordinating, monitoring, and utilizing national, State, and local health education resources. The Department of Education of the State of Florida, the administering organization, in cooperation with the State Health Agency was to prepare an analysis of the success of the State agency in implementing a model program for the delivery of a series of health education intervention activities. Specifically, the department was to provide support and technical assistance for development and evaluation of

procedures for dissemination and evaluation of performance-based outcomes on specific projects; establish an ad hoc committee for implementation of the Comprehensive Health Education Demonstration Model; employ a State coordinator to direct operations; involve pertinent State organizations in the overall effort; work intensively on four to six specific program areas selected from program models; stress programming for educationally and economically deprived persons; integrate project health education components into existing health and education efforts of other organizations; and develop a functional information system for dissemination of innovative or exemplary educational practices. Health education models that were to receive the most concentrated attention during the project included health education interventions in the Florida Panhandle area, a cancer and heart disease model for youth, the School Health Curriculum Project, the Breast Self-Examination for Junior High School Faculty and Girls Project, the Dental Health Curriculum Project, Alcohol Education Project, the Commissioner of Education's Student Recognition Program, and the Cardiac Pulmonary Resuscitation and First Aid Project.

81P-1168
Teenage Smoking Education Program.
National Interagency Council on Smoking and Health, 419 Park Avenue South, Suite 1301, New York, NY 10016
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1976 - October 1979.

The Teenage Smoking Education Program was designed to develop effective approaches to smoking control for school and nonschool groups. The program planning committee of the National Interagency Council (NIC) on Smoking and Health, the administering organization, provided guidance and support for the Youth Leadership Project. NIC personnel provided support to State and local interagency councils working on smoking prevention. Specifically, the NIC was to develop materials and resources and use organizational channels to inform member agencies and involve them in programming; publish descriptive articles in NIC publications and publications of member agencies; develop national press releases and other mass media materials; inform all member organizations of the Youth Leadership Project and of guidelines for submitting proposals for project grants; select and implement at least four new model project proposals; provide onsite consultation and assistance in selected areas; convene a meeting of the selected model program coordinators toward the end of the contract period to allow them to share ideas; sponsor a national leadership workshop to generate awareness of the selected project models; provide technical assistance to other communities, States, and localities interested in programming; develop summaries from each project for distribution to youth agencies and schools interested in developing similar programs; and develop and implement up to 20 workshops to implement the model youth projects. Quarterly progress reports and draft and final versions of a summary of all project activities were to be provided by the NIC.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-1169
Alcoholism and Alcohol Related Problems Among USAF Civilian Employees.
Manley, T. R.; McNichols, C. W.; and Stahl, M. J.
Wright-Patterson AFB, Ohio, Air Force Institute of Technology, School of Engineering, Department of Systems Management (AFIT Technical Report 79-4), 121 p., August 1979.
Available from: NTIS; Order No. AD-AO76599.

Questionnaires were administered to a random sample of Air Force civilian personnel from fall 1977 to fall 1978 in an attempt to estimate the nature and extent of their alcohol-related problems. Data from the 9,939 questionnaires returned indicated that 1.1 percent of the sample were chronically dependent upon alcohol. An additional 5.8 percent of the sample had experienced one or more serious problems related to drinking and were classified as adversely affected. A variety of demographic variables permit comparisons of alcohol-related problems among specific categories of respondents. Additional measurements of job satisfaction, work involvement, stress, and psychological dependence provide potential correlates for alcohol-dependent behavior. The survey instrument also collected data on respondents' attitudes about the impact of drinking on their careers. The study methodology and the nature of alcoholism makes prevalence estimates conservative. A copy of the survey instrument is appended. 34 references.

81-1170
Cancer Information in the Workplace: Education Materials for the Public and the Health Professional.
National Cancer Inst. (DHEW, NIH), Bethesda, Md. Cancer Information Clearinghouse.
Bethesda, Md., the Clearinghouse (DHEW Publication No. (NIH)79-2001), 58 p , May 1979.

Available from: ERIC; Order No. ED-175 469.

Annotated citations of literature and audiovisual materials concerning occupational carcinogens and of agencies and data bases dealing with the topic are provided for use by professionals involved in developing public, worker, and professional education programs. Professionals who will be most interested in the bibliography include health educators, industrial hygienists, and health care providers. The criteria for selection of items were availability and currency; items produced before 1970 were not considered. Each annotation includes the name, address, and telephone number of the source and the cost of the items, as well as a narrative description of the item's content. Six computerized data bases are described, and 13 committees on occupational safety and health and 10 educational resource centers of the National Institute for Occupational Safety and Health are listed along with the pertinent addresses and telephone numbers. Author, title, and subject indexes are provided.

81P-1171
Hospital Corporation of America Aerobic Challenge.
Davis, A.
Hospital Corporation of America, Center for Health Studies, One Park Plaza, P.O. Box 550, Nashville, TN 37202
June 1979 - Continuing.

The Hospital Corporation of America Aerobic Challenge program encourages employees of the corporation to develop a program of regular exercise. The program exercise facilities include a running track, weight-lifting equipment, shower and sauna areas, and sunlamps. The program provides monetary incentives for employees who participate in aerobic activities, such as bicycling, walking, running, and swimming. Approximately 30 percent of the employees participate in the program. The Hospital Corporation also sponsors three major runs in Nashville. A survey of program participants is scheduled at the end of 1981.

81P-1172
A Plan for Life--The IBM Health Education Program.
Beck, R. N. and Mandelblit, C.
International Business Machines Corporation, Office of the IBM Director of Benefits and Personnel Services, Armonk, NY 10504
February 18, 1981 - Continuing.

"A Plan for Life," the International Business Machine Company's health education program, assists employees who are interested in obtaining additional information and skills for maintaining good health. This comprehensive health education program offers courses in exercise, smoking cessation, stress management, weight management, back care, first aid, and cardiopulmonary resuscitation. Minicourses address general health, nutrition, and management of health risk factors. Local management personnel develop course schedules by using community resources and facilities. The courses are offered before and after work hours. Employees interested in taking equivalent courses in the community can apply for tuition assistance. The program is available to approximately 210,000 employees including full- and part-time employees and retired employees and their families.

HEALTH EDUCATION METHODOLOGY

81-1173
Planning a Do-It-Yourself Funding Search.
Abarbanel, K.
Health Education 9(5):8-12, September-October 1978.

The Foundation Center is a nonprofit organization that gathers, analyzes, and disseminates information on philanthropic foundations and their grants. The center offers health educators numerous resource tools for locating and acquiring funds; produces a wide variety of publications, many of which are generated from extensive computerized data banks; and operates national libraries in New York City and Washington, D.C. A network of 60 library reference centers in more than 45 States has also been established. The center has produced newsletters, a bimonthly grants index, and six editions of a foundation directory. The bimonthly index lists an average of 1,600 grant awards totaling $100 million. The sixth edition of the directory includes basic data on the country's 2,818 largest foundations, each of which has assets of over $1 million or awards grants in excess of $100,000 per year. The center also generates computerized printouts covering 57 subject areas and lists 1,977 grants awarded by over 340 major foundations.

81-1174
A Guide to Organizations, Agencies, and Federal Programs in Health Education.
Conway, S., ed.
Washington, D.C., Health Education Reports (Plus Publications, Inc.), 31 p., April 1980.

A list of private, public, and voluntary sources in health education is presented for those working in health educa-

tion and promotion. In addition to pertinent Federal offices and agencies, Federal programs are listed that specifically address alcohol, drug abuse, and mental health; consumer and community information and education; general health; nutrition; physical fitness and sports; regional health efforts; safety; and individual health concerns. State programs, governors' councils on physical fitness, and miscellaneous organizations and associations are also included.

81-1175
Learner Objectives Identified by Nutrition Educators.
Guthrie, H. A.
University Park, Pa., Pennsylvania State Univ., 9 p., 1979.
Available from: ERIC, Order No. ED-175 816.

In 1974, under the impetus of a grant from the Nutrition Foundation, the Nutrition Program at Pennsylvania State University began developing a nutrition curriculum, "Nutrition in a Changing World," to be integrated into other subject matter areas in elementary schools. The curriculum program, part of a community education program, included an inservice component designed to provide teachers of several subjects with a level of nutrition knowledge that would enable them to teach competently and a component that ensured inclusion of appropriate nutrition courses in college-level teacher training programs. All components were based on concepts identified by nutritionists working with the public in a wide variety of settings. The major emphasis of the elementary school curriculum was on nutrients. Professional nutritionists formulated a set of 15 skill, knowledge, and attitude areas for students. From this set, an expanded list of 40 learner objectives was derived during further analyses by field experts. Factor analysis of the results of a survey to rate the 40 objectives of a random sample of 1,000 members of the Society for Nutrition Education provided much of the conceptual framework for the curriculum development. Three methods of training teachers in the use of the curriculum have been developed; each method involves using videotapes. 3 references.

81-1176
Snohomish County Health Promotion-Health Education Issue Paper.
Health Council of Snohomish County, Everett, Wash.
Everett, Wash., the Council, 30 p., August 1979.
Available from: NTIS; Order No. HRP-0031646.

The Health Council of Snohomish County, Washington, has taken steps to emphasize the importance of health education in promoting health and preventing illness. Health education and promotion concepts include those associated with lifestyle; health services; environment; human biology; primary, secondary, and tertiary prevention; desired behaviors or outcomes; and teaching and learning theory. The health education system is modeled on the basis of demographic characteristics and the health status of county communities, individuals, groups, and families. Data on health status indicators in the county are kept. A survey of the 23 known health education providers in the county, interviews with administrators of all 4 county school districts, and contacts with 6 major industrial employers provided an overview of health education resources within the county. Data from these sources indicate that (1) leadership and coordination should be developed within a health promotion and education system; (2) efforts should focus on primary prevention; (3) schools should provide effective education for primary prevention for all students; and (4) an implementation committee with representatives from all interested groups and agencies should be organized.

81-1177
Health, Education and Promotion, Agenda for the Eighties: A Summary Report.
Kotz, H. J. and Fielding, J. E., eds.
New York, N. Y., Health Insurance Association of America, 56 p., 1980.

Representatives of nearly 60 of the nation's health insurance companies met in spring 1980 for the first industry-wide conference on health education and promotion. Topics at the meeting included an overview of health education and prevention; the effects of health care on health; new developments in health care; health promotion programs in industry; the case for prevention; health self-appraisal systems, means of motivating individuals to alter their behavior; health insurance incentives and disincentives; strategies for marketing health education; and the media, the insurance industry, and health. 13 references.

81-1178
Breast Cancer: Annotated Bibliography of Public, Patient, and Professional Information and Educational Materials.
National Cancer Inst. (DHEW, NIH), Bethesda, Md. Cancer Information Clearinghouse.
Bethesda, Md., the Clearinghouse. (NIH Publication No. 79-2002), 71 p., May 1979.

An annotated bibliography of public, patient, and professional audiovisual education materials offers information

for implementing breast cancer education programs. Citations cover benign breast disease, breast self-examination (BSE), other screening and detection methods, treatment methods, rehabilitation, breast reconstruction, methods of teaching BSE, the rehabilitative role of the health professional, and resources for health communications and planning. Title and subject indexes are included.

81-1179
Creative Teaching in Health.
Read, D. A. and Greene, W. H.
3rd ed. New York, Macmillan, 436 p., 1980.

Guidelines for establishing creative teaching techniques and curriculum development in the field of health education are provided for use by health educators and administrators. Topics include trends and ideas in health education, the teacher as a person, means of becoming an effective teacher, means of planning for health education, organization of the subject matter, creative use of instructional media, the nature of creative teaching, affective education, and teacher-student evaluation and professional growth. In addition, the guidelines cover the application of these teaching principles and techniques in educational efforts in the areas of mental health, human sexuality, drug education, health care and disease control, and health and physical fitness. Appendices include sources of information for sex education, communicable and infectious diseases, venereal diseases, and drug education. Numerous references.

81-1180
The Consumer Health Information Source Book.
Rees, A. M. and Young, B. A.
New York, Bowker, 450 p., 1981.

Annotated citations of the principal sources of health information for the layperson are provided for use by health consumers. Citations cover the current literature and organizations that provide health information on consumer health information, wellness, physical fitness, self-health care, children's health, women's health, health of the elderly, heart disease and stroke, cancer, diabetes, mental health, alcoholism and drug abuse, and other specific health problems and concerns. Items cited also include bibliographies, selection guides, magazines, journals, newsletters, professional literature, and Federal health information clearinghouses. An organizational guide to pamphlet suppliers; a directory of audiovisual producers and distributors; a directory of publishers; and author, title, and subject indexes are appended.

81-1181
Planning Health Education in Health Maintenance Organizations.
Roosen-Runge, U.
Atlanta, Ga., Bureau of Health Education (DHEW, CDC), Community Program Development Division, 49 p., May 1978.

Guidelines for establishing a health education program within a health maintenance organization (HMO) are presented for use by HMO staff with limited experience in health education. Topics include establishing goals and objectives, locating sources of planning information, choosing the method of education and congruent educational aids, and implementing and evaluating the program. An annotated bibliography of pertinent resources, lists of sources of health education information, and an outline of a survey questionnaire format are appended.

81-1182
A Selective Bibliography—Proposal Writing and Grant Sources.
Sliepcevich, E. M. and Vitello, E. M.
Health Education 9(5):5-7, September-October 1978.

A selective, annotated bibliography is presented for use by health educators in preparing proposals and grant applications. Citations include directories and indexes, periodicals, U.S. government publications, and miscellaneous references.

81-1183
Management of Non-Compliance to Medical Regimen: A Suggested Methodological Approach.
Toledo, J. R.; Hughes, H.; and Sims, J.
International Journal of Health Education (Geneva) 22(4):232-241, 1979.

An interpersonal methodology emphasizing physician-patient relations was used to manage six noncompliant minority parents of children with cardiac problems. A close physician-patient relationship was fostered through interviews that established a climate of empathy, sincerity, and interest in the client. The purpose of the interview should be explained to the family, and the physician should determine the parents' perception of health states, need for action, benefits, cost, and barriers to treatment. Parent compliance is encouraged by continuing to improve the physician-patient relationship and by explaining the medical condition. Case data involving one black and five Mexican American children, all of whom were from lower class families, indicate that the methodology was successful in enhancing compliance. Two case studies are appended. 26 references.

81-1184
Psychosocial Aspects of Genetics: A Selected Bibliography.
Weiss, J. O. and McNally, G.
(Rockville, Md.), National Clearinghouse for Human Genetic Diseases, 3 p., (197-).

A selected bibliography concerning the psychosocial aspects of genetics is presented.

81-1185
Food for the Health of It.
Wintle, C.
Somerville, Mass., Project Outside-Inside, Somerville Public Schools, 108 p., 1979.

Guidelines for implementing a healthy diet are provided for use by the general public. Topics include bodily processes involved in digestion and use of food, the body's use of carbohydrates and sugars, light and dark breads, the food industry, benefits of fresh foods, effects of fatty foods on the body, high-protein diets, and development of a healthy diet. A glossary is appended.

81P-1186
Health Awareness Programs for State Governments.
National Association of State Boards of Education, 1860 Lincoln Street, Suite 810, Denver, CO 80295
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1976 - December 1977.

"Health Awareness Programs for State Governments" was designed to review preventive health education efforts sponsored by State boards of education in six States and select two of the six for the development of health education and disease prevention awareness programs. Selected States were to be those which had (1) committed board of education members and health and education agencies, (2) knowledgeable State-level staff and sufficient health education resources, (3) potential for involvement of a variety of nongovernmental professional and other private organizations with sufficient resources, and (4) one or more State agencies or official organizations to assume responsibility for project activities. Furthermore, selected States were to be characterized by geographic isolation from other selected States and a demographically representative population. The National Association of State Boards of Education, the administering organization, was to conduct a 1- or 2-day health education awareness session in each of the 2 States for at least 20 people from 10 State program areas; prepare a comprehensive report on the total operation within each State; formulate a plan of action to launch similar health education awareness and improvement measures in other States; use established channels of communication and national and local meetings to inform member organizations about the project; and provide technical assistance for national assessment activities to evaluate health education knowledge, attitudes, and behaviors of children, youth, and adults. The association was to submit (1) a detailed plan of action within 30 days of the effective date of the contract, (2) quarterly progress reports, and (3) draft and final versions of a summary of all facets of the project.

PATIENT EDUCATION

81-1187
Books That Help Children Deal With a Hospital Experience.
Altshuler, A.
Rockville, Md., DHEW, Bureau of Community Health Services (DHEW Publication No. (HSA)78-5224), 21 p., 1978.
Available from: GPO Stock No. 017-031-00020-1.

An annotated list of books that help children prepare for a hospital experience is provided for use by parents, nurses, teachers, pediatricians, and physicians. Each entry includes author, publisher, year of publication, number of pages, type of illustrations, price, recommended age group, and an annotation. The list is prefaced by a discussion of criteria to be applied when making selections for particular children.

81-1188
Tuning Patients in to Health Education.
Carl, D.
Dimensions in Health Service (Toronto) 57(5):38-40, May 1980.

St. Clare's Mercy Hospital of St. John's, Newfoundland, has developed a health education television network available in patient rooms and lounges. Patient education programming began in 1977, 4 years after the introduction of television for educating interns and nurses. The content of the programs, which are broadcast 8 hours a day, 5 days a week, covers preventive topics such as alcohol education, safety instruction, postnatal exercises, and dental hygiene as well as curative topics for patients with specific health care problems. Half of the programs are produced at St. Clare's, while the remainder comes

from outside agencies. Recently, the hospital has expanded to produce televised health education programs that can be aired throughout the community. Interaction among the nursing staff, education coordinators, and the department of medical television ensures that programs are scheduled at times convenient to both patients and staff.

81-1189
Home Blood Glucose Monitoring: Benefits for the Patient and Educator.
Christiansen, C. and Sachse, M.
Diabetes Educator 6(3):13-21, Fall 1980.

During the 1980's, a significant number of diabetics will monitor their blood glucose at home, and health educators will need to prepare themselves to train clients in this technique. Home blood-glucose measurement techniques are especially useful to patients whose renal threshold for glucose is abnormal, patients with renal failure, unstabilized juvenile diabetics, patients with impaired color vision, patients who have difficulty recognizing hypoglycemia, and pregnant diabetics. The three blood-glucose monitoring systems currently available that utilize reflectance colorimeters are Eyetone, Dextrometer, and StatTek. The Dextrometer is the lightest, most compact, and easiest to use. Several short-cuts for the use of the measuring devices have been developed. Though no physician's prescription is necessary to purchase any of these devices or the test strips required for their use, a physician's involvement in the patient's decision is advisable. Insurance companies have been induced to reimburse purchasers, particularly after paying for a client's hospital visit that might have been avoided by the purchase of one of the devices. Teaching patients the use of a device, which can take place in an in- or outpatient setting, requires instruction in pricking the finger, preparing the reflectance meter, performing the actual test, recording the results, and caring for the instrument. 34 references.

81-1190
Training Patients for Continuous Ambulatory Peritoneal Dialysis at the Toronto Western Hospital.
Clayton, S., et al.
Excerpta Medica. International Congress Series No. 520:-162-166, 1980.

The home peritoneal dialysis unit of Toronto Hospital has two training beds, allowing the unit to train 30-35 kidney patients per year. Unit personnel include a medical director, a research fellow, a head nurse, two unit training nurses, a home visitation nurse, a part-time nurse who is responsible for tube changing, a technician, and a secretary. All end-stage renal failure patients are given a tour of the hemodialysis, peritoneal dialysis, and home peritoneal dialysis units. Family members are included in the patient education in home peritoneal dialysis. Patients are shown films of home training and receive counseling to allay their fears. The degree of self-care responsibility assigned to each patient depends on that patient's ability. After teaching the patient about the effects of renal failure and about simple tasks such as taking blood pressure, the patient is taught sterilization procedures, the surgical scrub, bag change techniques, tube change techniques, and techniques for changing dressings. Individualized attention by nurse trainers and the use of visual aids is stressed during the 10- to 14-day program. Prior to discharge, the patient must be able to answer written and oral questions and demonstrate practical and emergency skills. Followup home visits are provided at weekly intervals at first and then at intervals of 2 to 3 months. 1 reference.

81-1191
Cardiac Rehabilitation for the Patient and Family.
Davis, J. A. and Spillman, S. J.
Reston, Va., Reston Publishing Co., Inc. (Prentice-Hall), 162 p., (1980).

General information about disease is presented for use by cardiac patients and their friends and families. Topics include anatomy and physiology of the heart and related systems, coronary artery disease and risk factors, diagnostic procedures, cardiac catheterization, myocardial infarction, cardiac surgery, progressive activity and rehabilitation, pacemakers, and medications. Review questions follow each topic.

81-1192
Educators in Action: Education in the Discharge Planning Process.
Hollander, E. C.
Texas Hospitals 34(12):29, May 1979.

As a part of discharge planning, the Campbell Hospital in Weatherford, Texas, has implemented a patient education program that meets the needs of the physician, nurse, and patient. At the hospital, discharge is perceived as part of the total patient care process which includes nursing care plans, education programs, and retrospective audits. Primary responsibility for patient education is given to the nursing staff. The discharge planning procedure involves initiation of a discharge planning summary form that includes a nursing assessment and a brief statement of pa-

tient education plans; documentation of patient teaching; deviations from the planned education program; and review by the audit committee using the admission data, the nursing care plan, the discharge planning form, and other supporting documents.

81-1193
Application of the Readability Concept to Patient-Oriented Drug Information.
Morris, L. A.; Meyers, A.; and Thilman, D. G.
American Journal of Hospital Pharmacy 37(11):1504-1509, November 1980.

A study of 199 college students was designed to assess the readability of 4 patient-labeling documents on diazepam, a minor tranquilizer. The labeling documents were prepared to inform patients concerning diazepam uses, side effects, adverse effects, and potential for dependency. All documents contained the same basic information, but differed in vocabulary and complexity of sentence structure. A questionnaire was administered to all student subjects, each of whom was asked to read an excerpt from one of the four documents. The questionnaire included a vocabulary test on 10 medical terms and a section for rating accuracy, clarity, appeal, and readability of the materials. The documents were also analyzed independently by 2 judges using 13 readability formulas. The study group exhibited wide variations in their understanding of medical terms; the terms were correctly identified by most subjects, with the exception of the term "pulmonary," which was defined correctly by only 28 percent of the group. Ratings for accuracy and quality were similar for all four documents. The easiest-to-read excerpt was rated lowest on interest value, positive evaluation, and adult readability. The study group's estimates of readability varied from higher to lower than the readibility test's estimates. The study indicates that there are problems with relying on readability scores for assessment of difficulty and that patient labeling should be prepared for audience acceptance rather than for favorable reading scores. 27 references.

81-1194
Coping with Cancer: An Annotated Bibliography of Public, Patient, and Professional Information and Education Materials.
National Cancer Inst. (DHEW, NIH), Bethesda, Md. Cancer Information Clearinghouse.
Bethesda, Md., the Institute (NIH Publication No. 80-2129), 113 p., May 1980.

An annotated bibliography of public, patient, and professional information and educational audiovisual materials is presented for use by health educators and health care providers. Audiovisual teaching aids include those addressing childhood cancer; cancer in adults; personal narratives; and means of coping with breast cancer, head and neck cancer, leukemia, lung cancer, and colorectal cancer. Within these categories, citations are classified in two ways: those for use by patients and the general public, and those for use by professionals.

81-1195
Coping with Cancer: A Resource for the Health Professional.
National Cancer Inst. (DHHS, NIH), Bethesda, Md. Office of Cancer Communications.
Bethesda, Md., the Office (NIH Publication No. 80-2080), 145 p., September 1980.

Guidelines for dealing with cancer patients and their families are provided for use by health professionals. Topics include psychosocial issues related to cancer, effects and treatment of cancer, coping mechanisms of the family and the health professional, and financial aspects of cancer. Appendices include a list of support programs, a patient's bill of rights, a list of sources of current psychological research in the field, and a list of telephone information services.

81-1196
A Supplemental Listing of Materials on Hemophilia.
National Clearinghouse for Human Genetic Diseases (DHHS, HSA), Rockville, Md.
Rockville, Md., the Clearinghouse, 4 p., March 5, 1980.

A supplemental listing of patient educational materials on hemophilia is presented along with names and addresses of sources of materials cited.

81-1197
A Selected List of Lay Materials on Genetic Diseases.
National Clearinghouse for Human Genetic Diseases (DHHS, HSA), Rockville, Md.
Rockville, Md., the Clearinghouse 16 p., August 25, 1980.

A list of selected educational materials on genetic diseases is presented for use by lay audiences. Materials listed include pamphlets and brochures, books, and audiovisual aids. Addresses of the sources of the materials are appended.

81-1198
Prenatal Diagnosis and Genetic Counseling: A Selected List of Lay Materials.
National Clearinghouse for Human Genetic Diseases (DHHS, HSA), Rockville, Md.
Rockville, Md., the Clearinghouse, 7 p., June 20, 1980.

Educational materials addressing prenatal diagnosis of genetic diseases and genetic counseling are provided for use by lay readers and viewers. Printed materials, films, filmstrips, and audiocassettes are included on amniocentesis, birth defects, and causes and treatments of genetic disorders.

81-1199
Patient Compliance in Rheumatic Diseases.
National Inst. of Arthritis, Metabolism and Digestive Diseases (DHHS, NIH), Bethesda, Md. Arthritis Information Clearinghouse.
Bethesda, Md., the Clearinghouse, 2 p., December 1979.

A selected, annotated bibliography of materials on patient compliance with prescribed treatment regimens for rheumatic diseases is provided. 12 references.

81-1200
Patient Education Programs in Arthritis: A Selected Bibliography.
National Inst. of Arthritis, Metabolism and Digestive Diseases (DHHS, NIH), Bethesda, Md. Arthritis Information Clearinghouse.
Bethesda, Md., the Clearinghouse, 2 p., 197-.

A selected, annotated bibliography of patient education programs for persons affected by arthritis is provided. 6 references.

81-1201
Patient Education--Program Design: A Selected Bibliography.
National Inst. of Arthritis, Metabolism and Digestive Diseases (DHHS, NIH), Bethesda, Md. Arthritis Information Clearinghouse.
Bethesda, Md., the Clearinghouse, 2 p., March 1979.

A selected, annotated bibliography of education program designs for use with arthritic patients is presented. 8 references.

81-1202
Arthritis Patient Education Program Materials.
National Inst. of Arthritis, Metabolism and Digestive Diseases (DHHS, NIH), Bethesda, Md. Arthritis Information Clearinghouse.
Bethesda, Md., the Clearinghouse, 2 p., June 1980.

A selected, annotated bibliography of education program materials for arthritic patients is provided. 14 references.

81-1203
Inpatient Home Training for Continuous Ambulatory Peritoneal Dialysis.
Prowant, B. and Fruto, L. V.
Excerpta Medica. International Congress Series No. 520:-158-161, 1980.

The continuous ambulatory peritoneal dialysis (CAPD) inpatient home training program at the University of Missouri Medical Center at Columbia has trained 32 patients in 10 months. Larger hospitals or programs can utilize specialized areas for inpatient training and offer low nurse-to-patient ratios and specialized staff training, avoiding problems in communication and quality of patient care. Most patients complete the training program in about 10 days, spending 2 to 3 hours in training each morning and afternoon. Home training usually begins with a discussion of basic concepts and progresses to application of these concepts in planning self-care. To decrease the risk of contamination, models are used to demonstrate procedures and practice techniques. The use of a training manual and audiovisual aids allows the learner to review and study when the nurse is not present. Written and verbal evaluations of patient knowledge and skills precede discharge. The 24-hour availability of professional nursing care is the major advantage of inpatient CAPD training. Tailoring the dialysis scheduling to meet the patient's home needs allows dialysis requirements to be established without requiring major adjustments after discharge. Hospitalization, however, does place psychological stress on the patient. Patient followup involves telephone contacts, outpatient clinic visits, and home visits. Inpatient CAPD programs are excellent complements to outpatient CAPD programs. 3 references.

81-1204
Patients' Rights in Decision Making: The Case for Personalism Versus Paternalism in Health Care.
Schain, W. S.
Cancer 46(4, Suppl):1035-1041, August 15, 1980.

The emphasis on comprehensive care includes not only treatment of the disease but physician-patient communi-

cation. The range of interaction that characterizes the physician-patient relationship includes the situation in which the physician paternally directs passive patients; the situation in which patients are given information about their condition, with the physician viewed as the ultimate authority; and the situation in which the physician and patient mutually decide the latter's course of action. The consumerism involved in the third and presumably optimal model, which allows patients to exercise their rights in decision making, requires careful examination and information exchange between physician and patient. Questions that must be answered include what information will serve what purpose, for what patients is such information valuable and in what depth and context, what is the appropriate time to introduce information, whose responsibility is it, and what media is most appropriate for presenting various types of information. 10 references.

81-1205
The Role of the Physician.
Seedat, Y. K.
South African Medical Journal (Cape Town) 56(9):343-345, August 29, 1979.

Physicians must cease to view symptomless hypertension as a benign disease; they must reduce the present incidence of morbidity and death caused by uncontrolled hypertension by educating colleagues, organizing screening programs, and ensuring cooperation between the medical profession and the public media. Steps that a physician should take in reducing hypertension in patients include prescribing hypertension booklets and teaching patients to take their own blood pressure, questioning patients closely about their medication before their blood pressure is taken on each visit after treatment is started, and prescribing routine followup appointments at regular intervals. Obese hypertensives should be urged to lose weight. A hospital survey has demonstrated that blood pressure measurements are often omitted by admitting physicians. Patient examinations in hospital settings should include a full assessment of primary and secondary symptoms of hypertension. 10 references.

81-1206
Prepregnancy Counseling: A Logical Prelude to the Management of the Pregnant Diabetic Woman.
Steel, J. M.; Parboosingh, J.; Cole, R. A.; and Duncan, L. J. P.
Diabetes Care 3(2):371-373, March-April 1980.

A pregnancy counseling clinic for diabetic women 14-40 years old was set up by the Diabetic Department of the Royal Infirmary and the Department of Obstetrics of Simpson Memorial Maternity Pavilion in Edinburgh, England. Letters were circulated to all insulin-dependent females in the age group; notices were posted in the departments; and professionals were instructed to inform all affected women. Patients (and their husbands) were seen by the physician treating them for diabetes and by the obstetrician in order to (1) determine the possibility of diabetic complications, (2) obtain maximum cooperation by the husband and wife, (3) identify the time of conception, (3) obtain optimum diabetic control at the time of conception, (4) identify any gynecological abnormality, and (5) avoid infection with rubella. Of the 37 patients seen at the prepregnancy clinic, 4 were advised against pregnancy, 11 delivered infants, and 3 are currently pregnant. Clinic staff are attempting to reduce the number of target patients not attending the clinic by discussing the problem with the infrequent visitors and younger patients. Informal assessments by the staff and results of questionnaire evaluations indicate that the clinic improves the motivation of patients and their cooperation throughout the long period of intensive care that pregnancy entails. 8 references.

81P-1207
Lovelace-Bataan Health Program Patient Education Project.
Lovelace-Bataan Health Program, 5400 Gibson Boulevard, S.E., Albuquerque, NM 87108
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1974 - June 1976.

The Lovelace-Bataan Health Program Patient Education Project was designed as a comprehensive health education and high-risk disease prevention program for the health program patients. Through its relationship with the Department of Health, Education, and Welfare's health maintenance organization (HMO) and the Department's various national training workshops and symposia, the project staff was to encourage and foster disease prevention measures, including smoking control, in HMO's. Specifically, program staff were to develop audiotapes for patient education; establish a system to develop and disseminate health education programs and materials, including audiovisual aids, smoking cessation clinics, and articles for patient newsletters; incorporate effective disease prevention techniques into the ongoing activities of the program's clinic, hospital, extended care facility, and rehabilitation center; encourage and assist other HMO's to strengthen primary prevention activities through regularly scheduled seminars for HMO executives, regional conferences, and presentations at national meetings; con-

duct a 1-day conference for health education specialists from HMO's throughout the region to encourage the use of preventive interventions and health education measures; and develop a plan and methodology to increase health education and disease prevention activities as integral parts of HMO services. The staff was to submit quarterly progress reports, draft and final versions of the HMO plan and methodology, and a final report summarizing the activities of the project.

81P-1208
Patient Education at Roosevelt Hospital.
Institute of Public Affairs, 801 Second Avenue, New York, NY 10017
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
May 1977 - April 1978.

"Patient Education at Roosevelt Hospital," a study conducted by the Institute of Public Affairs in New York City, was designed to describe two major patient education endeavors at that hospital. The first report was to describe the utilization of pediatric clinics, and the second was to cover educational activities for asthmatic patients and their families. The reports were to describe background situations related to the patient education programs; funding, staffing, and administrative procedures; program objectives; program activities; evaluation plans; methods of collecting and storing data; data-processing equipment used; analytical processes used to assess program effectiveness; major problems encountered and their resolutions; and evidence of changes in the behaviors or attitudes of patients, families, health care providers, and support staff. The reports were to include recommendations for use of the described approaches by others. The institute was to submit working outlines for final reports 30 days after the effective date of the contract, a draft version of the final report 5 months after the effective date of the contract, and a final report 6 months after the effective date of the contract.

81P-1209
Tennessee Valley Authority (TVA) Patient Education Program.
Tennessee Valley Authority (TVA), Human Resources Branch, Knoxville, TN 37902
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
October 1978 - June 1979.

The Tennessee Valley Authority (TVA) Patient Education Program was designed as a pilot project for diabetic and hypertensive patients in Scott and Hawkins Counties in rural eastern Tennessee. Three videotapes on each disease were to be developed for use as educational aids for the patient and the patient's family by the audiovisual department of the College of Nursing at the University of Tennessee in Knoxville. Project staff were to recruit physicians, nurses, dietitians, physical therapists, patients, and family members to stage the presentations to be taped. The use of patient models to educate other patients was to be central to the production of the tapes. Both series of videotapes were to be distributed through Scott County Hospital in Oneida and Hawkins County Memorial Hospital in Rogersville. Faculty members and senior nursing students from the university were to instruct staff in each hospital in the use of the tapes. Evaluation of the impact of the tapes was to involve using eight senior nursing students as leaders of small patient and family education groups, who would view the tapes as part of an educational program. Questionnaires designed to assess the attitudes and knowledge of the patients were to be administered to patients before and after the educational intervention using the tapes. Local physicians would be informed of the program through the participating counties and the medical staff in the participating hospitals so that they could refer patients for educational intervention.

PROFESSIONAL EDUCATION AND TRAINING

81-1210
Potential Patterns: How Do You Talk to Patients About T'ai Chi and Herbal Teas?
Hanavan, F. V.
Journal of Allied Health 9(2):143-145, May 1980.

The response of allied health professions to the growing health education and health promotion movement could enhance health care delivery significantly. Allied health professionals should keep abreast of developments in health promotion by reading new publications including recent reports by the Surgeon General and the W. K. Kellogg Foundation. These readings coupled with their professional experiences will allow allied health personnel, who often enjoy extended relationships with patients, the background necessary to implement health promotion programming. Education programs in allied health should begin to include courses on health promotion. Finally, the health educator should be encouraged to join the health care delivery team. 3 references.

81-1211
Facts About Drug Abuse: Trainer's Manual.
Link, W. E.; Hochman, R.; and Casey, E.
Gaithersburg, Md., National Drug Abuse Center for Training and Resource Development, Manpower and Training Branch, National Institute on Drug Abuse (DHEW, ADAMHA) (Publication No. (NDACTRD)79-FADA-043T), 1 v., November 1978.
Available from: GPO.

Informational guidelines for persons who wish to act as trainers in drug abuse education programs are provided. The 25-hour program outlined can be implemented over a 3-day period in 9 individual modules. Topics include problems of current definitions and perceptions of drugs, drug abuse, and drug addiction; a social and historical context for understanding substance use in the United States; substance effects and potential hazards; means of understanding and overcoming substance dependence; prevention and the community, school, family, peers, and youth; roles and strategies for prevention efforts; and means of evaluating drug education programs. Each project is covered in module form, and each module includes a discussion of the perspective, objectives, materials required, and trainer activities, as well as an overview of the module and an outline of the lectures included in the module. Copies of evaluation instruments are appended.

81-1212
Drugs in Perspective: Trainer's Manual.
Link, W. E.; Hochman, R.; Miller, L. P.; Fischer, B. E.; and Siegel, R. K.
Rockville, Md., National Institute on Drug Abuse, Division of Resource Development, Manpower and Training Branch (DHEW, ADAMHA) (Publication No. (NDACTRD)79-053T), 306 p., 1979.
Available from: GPO.

Informational guidelines for those who wish to act as trainers in drug education programs are provided. The course outlined is composed of 8 modules and requires 26 hours and 30 minutes of classroom time over 4 days. Topics receiving attention include perspectives on substance use and abuse; a social and historical context for understanding substance abuse in the United States; psychoactive drugs in a pharmacological context; means of understanding substance abuse; approaches to the treatment of substance abuse; prevention approaches and strategies; and means of evaluating drug education programs. Each module includes a discussion of the module perspective, objectives, and materials required, as well as an overview and outlines of all module lectures. Copies of evaluation instruments are appended.

81-1213
Training Professionals to Support and Increase the Competence of Young Parents.
Murphy, N.
Journal of Nursing Education 17(7):41-42, 45-49, September 1978.

To enable graduate nursing students to acquire skills in child growth and development and family development, a one-semester course has been developed for first-year pediatric students at the University of North Carolina at Chapel Hill. The course provides an opportunity for long-range supervised work with children and their adolescent parents in their home or community environments. The student selects an adolescent family (chosen through the local health departments) and meets with the faculty advisor and the public health nurse to plan the semester's experience. The public health nurse acts as a liaison between the student and public resources and agencies. Students formulate objectives, visit the families each week, write reports and evaluations of each visit, hold weekly conferences with the faculty advisor, and participate in weekly seminars on developmental theory and small group clinical conferences held six times throughout the semester. In addition to the small group clinical conferences, a recent course requirement for students from the School of Public Health has been 15 weekly 2-hour seminars on family health care, which are team taught by a multidisciplinary group of professionals. The course has improved students' skills in supporting and facilitating parenting capabilities. Student evaluations have emphasized the value of small group clinical conferences, individual conferences with the faculty advisor, and collaboration with professionals from several disciplines.

81-1214
Role Delineation Project for Health Education [illegible]-tive Summary of the Final Report.
National Center for Health Education, San Francisco, Calif.
San Francisco, Calif., the Center, 5 p., 1979.
Available from: NTIS; Order No. HRP-0902202.

A workshop on similarities and differences among health educators and the role and function of entry-level health educators was held in February 1978 to assess the feasibility of establishing general preparation and practice standards for health educators and to discuss a focus for future quality assurance efforts. The advisory group responsible for planning the workshop's program became a national task force on the preparation and practice of health educators. The task force obtained the cooperation of the National Center for Health Education and the Division of

Associated Health Professionals, which together organized a working committee. The committee, which met six times, and the project staff, which provided materials for the meetings and communicated with health educators nationwide, used a process of consensus to develop appropriate roles. Recommended role competencies of the entry-level health educator include communicating health and health education needs and resources, determining the focus of health education, implementing and evaluating programs, coordinating health education activities, and acting as a resource for health and health education. Areas of responsibility were subdivided by function, and skills and knowledge were specified for each function.

81-1215
Patient Education: A Handbook for Teachers. Report of the National Task Force on Training Family Physicians in Patient Education.
National Task Force on Training Family Physicians in Patient Education.
Kansas City, Mo., Society of Teachers of Family Medicine, 180 p., December 1979.

Performance-based guidelines and recommendations for the training and evaluation of family practice residents in patient education, and a strategy for encouraging the incorporation of the guidelines into the training and certification of family physicians, are offered as a stimulus to family physicians and family practice residency programs. Topics addressed include the rationale for patient education, legal issues in patient education, patient education training in a family practice residency program, and a patient education primer. Appendices include proposed family physician competencies in the area of patient education, a checklist for assessing patient education materials, an overview of the scope and content of patient education, recommended readings in the area of patient education, and sources of health and patient education materials.

81-1216
Relationship Between Medical Audit Results and the Planning of Continuing Medical Education Programs.
Osborne, C. E.
Medical Care 18(10):994-1000, October 1980.

Medical audit committee chairmen from central and southern Illinois general hospitals were interviewed to determine the relationship between medical audit results and planning for continuing medical education (CME) programs. Chairmen were asked about the purpose of their medical audits; how topics were determined; and their committees' competence at developing, conducting, and following up on the results of their audits. Questions were also designed to investigate the usefulness of these audit results in planning formal CME activities. Interviews were conducted with 75 chairmen from 70 hospitals: 32 chairmen from small hospitals, 18 from medium hospitals, 12 from large hospitals, and 13 from hospitals that had departmental audit committees. Seventy-nine percent of the chairmen indicated that the Joint Commission on Accreditation of Hospitals' (JCAH) requirements were at least partially responsible for their hospital's conducting audits. More than 50 percent of the chairmen from small hospitals and 25 percent of the other chairmen indicated they would suspend conducting audits if the JCAH requirements were lifted. While 80 percent of the chairmen believed an audit was a good method of planning CME programs, only 23 percent could identify a CME program that had been developed because of an audit. 24 references.

81P-1217
National Health Education and Primary Prevention Program for Medical Students.
Student American Medical Association, 1171 Tower Road, Schaumberg, IL 60195
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
May 1975 - May 1978.

The National Health Education and Primary Prevention Program for Medical Students was a nationwide program administered by the Student American Medical Association (SAMA). An advisory committee comprised of five prominent medical students and other experts in medical and allied health fields was to meet at least twice a year to oversee program development and provide liaisons with all components of the organization and with other national medical and student organizations. SAMA was also to develop educational information and materials for the organization; develop three education and prevention packets for use by students in community health education presentations; examine medical school curricula for both prevention and cancer education courses; develop a model curriculum dealing with prevention of disease and emphasizing cancer prevention; select five chapters of SAMA to initiate and perfect prevention approaches for patient education; develop health education programs for medical students directly involved in the special SAMA projects; and initiate cooperative health education activities with national medical and health organizations, particularly student organizations. SAMA was to submit quarterly reports, a draft of the final project report 30 days prior to the expiration date of the contract, and the final report on or before the expiration date of the contract.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-1218
A View of the Future: A Statement of Position to Stimulate Discussion.
Gage, R. W.
Journal of the American College Health Association 26(1):53-59, August 1977.

The essential issues facing college and university health workers in the development of a national health policy are the effectiveness of primary prevention and the allocation of resources among health and other high-priority social goals. Subsidiary issues facing health providers are related to the practical limit to national expenditures for health services; means of assuring that resources invested in health produce high-quality care; social willingness to monitor and control environmental threats to health; the extent to which postponing morbidity and mortality can be considered worthwhile; social acceptance of proper nutrition, adequate exercise, and a supportive physical and social environment as the goal of health promotion efforts; willingness among health providers to act in consultation with consumers to determine health goals and allocate resources; and the ability of the allocative and regulatory functions of the Government to promote equity and effectiveness in the area of health. Similarly, educators must ask themselves questions concerning the goals of higher education and how realistic those goals are, the ability of institutions of higher education to accommodate democratization of their governance while maintaining social accountability for their services, and the ability of such institutions to function within allocation budgets. An assessment of the strengths and weaknesses of college and university health workers indicates that the future will witness a redefinition of goals, new means of allocating resources, and emphasis on outcome assessment. 3 references.

81-1219
28.3495 Grams of Prevention (Editorial).
Gray, D. E.
Journal of the Kansas Medical Society 81(6):302-303, June 1980.

Health promotion may be the most viable means of containing rising medical costs and improving the health status of people in the United States. Unfortunately, a comprehensive health promotion program, supported by the medical profession, insurance companies, and the Government, would have to overcome charges made by alternative health movements that the program supported by such organizations would be an orthodox movement with little understanding of the needs of the populace. Such a movement would require the full cooperation of physicians and the multitude of ancillary personnel in the promotion effort as well as efforts to reduce territoriality among these professionals. Such a team would minimize the intrusion of bureaucrats or alternative health personnel.

81-1220
Invited Response to Congressman Richmond: The Food and Nutrition Board's Approach to Nutrition Education.
Olson, R. E.
Journal of Nutrition Education 12(4):188-189, October-December 1980.

The author states that, contrary to the charges of Congressman Fred Richmond (14th District, New York), the Food and Nutrition Board (FNB) has remained within its traditional role in advising the public on proper dietary habits in its recent publication of Recommended Dietary Allowances (RDA). Before publication, the FNB surveyed medical literature on the relationship of diet to disease. In its final recommendations, the FNB suggested that Americans eat moderately; avoid alcohol, sugar, fats, and oils; increase physical activity; and use salt in moderation. The fact that these guidelines differ in some respects from those outlined by the Department of Agriculture and the Department of Health, Education, and Welfare is not reason to suggest that the FNB is denying the importance of preventive medicine or attempting to reduce the significance of coronary heart disease as a cause of death in the United States. 12 references.

81P-1221
Model Program in Public Health Education.
New York State Public Health Association, P.O. Box 271, Mineola, NY 11501
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
April 1976 - April 1977.

The New York State Public Health Association Model Program in Public Health Education was designed for implementation in State health departments. Association staff were to involve appropriate health and education experts in conducting a study to assess public health education programs, functions, activities, and resources in selected official State health agencies; develop a general philosophy about the role of the public health education

units in State health agencies and the general mission of such organizations; develop an outline of recommendations regarding objectives, responsibilities, functions, programs, specific activities, staffing patterns, resource needs, and measures for assuring accountability and evaluation; and delineate means of cooperation among State health department public health education units and other State, local, and Federal health and education agencies. Progress reports were to be submitted 90 and 270 days after the effective date of the contract, and a final report on all project activities was to be submitted by the expiration date of the contract.

RESEARCH AND EVALUATION

81-1222
Analysis of a Follow-Up Study of Genetic Counseling.
Abramovsky, I.; Godmilow, L.; Hirschhorn, K.; and Smith, H., Jr.
Clinical Genetics (Copenhagen) 17(1):1-12, 1980.

A followup study of 212 families for whom genetic counseling had been provided was performed to assess the effectiveness of the genetic counseling service at the Mount Sinai Medical Center in New York City. The counselees ranged from 18 to 45 years old; 83 percent were white, 15 percent Hispanic, and 2 percent black. A 31-item multiple-choice questionnaire was administered to the families to determine the degree of recall of essential medical facts and the degree of satisfaction with the service. Seventy-two percent of the subjects returned the questionnaires. Data analysis consisted of a computerized comparison between the counselees' responses to the questionnaire and the corresponding information contained in the medical records. Results of the analysis indicate that (1) adequate recall of the genetic information was demonstrated by 74 percent of the respondents; (2) 80 percent of the respondents described their counseling experience as favorable; (3) a direct relationship was found between the degree of satisfaction and whether the counselees had received counseling in the desired format; (4) 62 percent of the counselees who reached a decision about having children indicated that genetic counseling influenced that decision; (5) a significant negative correlation was found between the magnitude of occurrence or recurrence risk and the decision to have another child; and (6) some decisions were modified by counselees' subjective interpretations of the burdens associated with the disorder in question. The questionnaire survey appears to be a valuable tool. Numerous references.

81-1223
Human Sexual Information as High Priority of College Students.
Hyner, G. C. and Stevens, R.
Journal of the American College Health Association 29(2):88, October 1980.

The Student Health Service (SHS) of the University of Pittsburgh used health-information tape recordings to determine the health concerns of its university community. Data were collected for 3 weeks on all telephone requests for individual health-information tapes at the Pittsburgh Health Education Center. Brochures listing the hundreds of available health topics had been available on campus for a semester prior to data collection. Results of the survey indicated that student interest focused on masturbation, sexual responsiveness, homosexuality, contraceptive methods, venereal infections, vasectomy, pregnancy symptoms, and natural family planning. These interests correlated highly with the interests of the general public during the study period. In response to this data, SHS professionals produced topical information sheets, media presentations, classroom and dormitory programs, and group and individual discussions. Health care providers found these materials helpful, and an academic course in human sexuality received additional support after the completion of the survey.

81-1224
Public Awareness and Knowledge About the Risks of Drinking During Pregnancy in Multnomah County, Oregon.
Little, R. E.; Grathwohl, H. L.; Streissguth, A. P.; and McIntyre, C.
American Journal of Public Health 71(3):312-314, March 1981.

A telephone survey of 550 Caucasian residents in an urban area in northwest Oregon was conducted to assess the residents' knowledge of the effects of alcohol consumption during pregnancy and their behavioral recommendations in this area. Seventy-eight percent of the 550 completed calls resulted in interviews. The interview protocol, which was ostensibly focused on health, contained questions that could elicit beliefs about the effects of alcohol use on a pregnant woman and her fetus. Approximately 90 percent of the respondents stated spontaneously that drinking might be harmful, and 25 percent of this group thought pregnant women should abstain from drinking alcohol. The balance of those who considered drinking harmful felt that an average of more than three drinks per day was safe. Thus, awareness of risk does not necessarily result in recommendation of low-risk behavior. 8 references.

81-1225
Evaluation of a Respiratory Health Education Program.
MacPherson, B. V.; Ashikaga, T.; Dickstein, M. S.; and Jones, R. P., Jr.
Journal of School Health 50(10):564-567, December 1980.

A study involving a representative sample of 8 of the 56 school superintendencies in the State of Vermont was designed to compare three curricular approaches formulated to provide respiratory hygiene information to rural elementary school students in grades 4 through 6. The three approaches tested were (1) use of an enclosed van equipped with several "hands-on" displays to provide mobile classroom education, (2) use of a traditional classroom curriculum method, and (3) a combination of these two approaches. Students were surveyed in the fall of 1977 and again in the spring of 1978, before and after exposure to the curricular interventions. The questionnaire used included demographic items, four cognitive tests, eight attitudinal scales, and two smoking behavior items. Data from questionnaires completed by 1,750 pupils in 85 classrooms during the fall of 1977 and by 1,683 pupils in 80 classrooms in the following spring indicated that students exposed to the mobile unit or traditional intervention alone exhibited significantly greater increases in knowledge when compared to a control group and that no group exhibited significant attitudinal or behavioral improvement. That the mobile unit was as effective as the classroom approach should be noted by health educators who might find this approach more appealing or cost effective. 17 references.

81-1226
Knowledge of Cancer: A Cross-Cultural Comparison Among Students in the US and the UK.
Michielutte, R.; Diseker, R; and Hayes, D.
International Journal of Health Education (Geneva) 22(4):242-248, 1979.

A comparison of the results of a survey of 3,537 high school students attending 4 high schools in Manchester, England, with data from a survey of 295 students from 7 junior high schools in Winston-Salem and Forsyth County, North Carolina, allows evaluation of these populations' knowledge of cancer. Comparison of the results of the two studies indicated that (1) television is the source of information most frequently mentioned by either population; (2) newspapers, magazines, and books were also rated highly as sources by both groups; (3) British students identified parents and friends as sources much more often than did their American counterparts; (4) 60 percent of the American sample and 90 percent of the British sample identified smoking as a cause of cancer; (5) American students were somewhat more aware that pollution and exposure to chemicals and radiation cause cancer; (6) neither group believed that cancer was infectious; and (7) Americans are more likely to believe that cancer is inherited. Studying about cancer in school seemed to have little bearing on the results. Results indicate a need for implementation of a chronic disease control model at the secondary school level. 4 references.

81-1227
Highlights from the National Survey on Drug Abuse: 1979.
Miller, J. D. and Cisin, I. H.
Rockville, Md., National Institute on Drug Abuse, ADAMHA, PHS, DHHS. (DHHS Publication No. (ADM)80-1032), 34 p., 1980.

Highlights from the most recent findings of a continuing nationwide research effort sponsored by the National Institute on Drug Abuse provide extensive data on the use of a broad spectrum of legal and illegal substances by youth, young adults, and older adults. The 1979 National Survey on Drug Abuse consisted of personal interviews with over 7,000 respondents 12 years old and above, randomly selected from the population of the United States. Data were collected on the percentage of each population group that has ever tried marijuana, cocaine, hallucinogens, or heroin; on the percentage of each group that reported using these drugs during the month prior to the interviews; on demographic correlates of drug abuse; on the influence of the family on drug use; on trends in illicit drug use between 1960 and 1969; and on the perceived consequences of marijuana use. 5 references.

81-1228
Sex Roles as Variables in Preventive Health Behavior.
Nathanson, C. A.
Journal of Community Health 3(2):142-155, Winter 1977.

A review of the literature on preventive health behavior indicates that males in Western cultures engage in more risk-taking behavior and take preventive measures less frequently than their female counterparts. This situation is particularly true when preventive action requires medical intervention. The literature supports the hypothesis that these differences in behavior arise out of the socialization process and the adult role patterns that society defines as appropriate for each sex. Women are encouraged to define their problems in medical terms and to seek help for them within the medical care system. Only recently have

smoking, drinking, and other behaviors conducive to coronary heart disease come within the purview of medical attention. A possible explanation for this inattention is that these activities have been perceived as inevitable and even valued components of the male role and, consequently, as not controllable by medical means. 90 references.

81-1229
The Self-Concept of Disadvantage: Factors Which Facilitate or Hinder Change.
Ogionwo, W.
International Journal of Health Education (Geneva) 22(4):216-226, 1979.

Data from interviews with 68 physically disabled soldiers in a rehabilitation home at Oshodi in Lagos, Nigeria, reveal ways the disabled perceive their disability and provide insights into how self-concept affects successful performance. In addition to the disabled persons, the medical, paramedical, and other staff were interviewed. The interviews revealed that rehabilitation personnel verbally and mentally labeled the disabled and thereby modified their self-image. Other members of the community responded to the labels by changing their expectations of the disabled. The process led to alienation and isolation of the disabled and to adoption of a self-concept of disadvantage. Analysis of 29 interview items designed to determine how the handicapped accepted their disability suggests that handicapped patients do not have integrated attitudes toward their disabilities. Rather, factors associated with social loss, feelings of despondency, obliterative adjustment (a failure to recognize the effects of disability), subordination of physical characteristics (replacing the importance of physical characteristics with new characteristics of personality or social relationships), coping, enlargement of patient's values beyond the disability, accommodation, and overcompensation are relatively independent of one another. These findings confirm studies from the United States suggesting that placing children in various "problem" categories through labeling can damage children's self-concepts. 17 references.

81-1230
Evaluation--The Classroom Dilemma.
Shaw, D.
Health Education 8(2):5-6, March-April 1977.

The lack of a standardized instrument that can be used with any degree of confidence to measure the effectiveness of a health education program points to the need for focusing attention on well-organized test construction by individuals teaching health classes. Steps involved in developing reliable evaluation instruments include (1) identification in writing of the objectives of the health education intervention; (2) construction of test items that adequately evaluate all items identified in the specification of objectives; (3) analysis of test items to ensure their statistical validity; and (4) formulation of an attractive test with clear instructions. In selecting items, the educator should consider class size, length of testing period, method of correcting and scoring, convenience, and student and teacher feedback. To ensure that all levels of understanding are assessed, questions that assess memory, translation, interpretation, application, analysis, synthesis, and evaluation of facts should be included. Analysis of the difficulty of each item on the test can easily be accomplished by computing the percentage who answered the question incorrectly. The teacher should then select items with varying degrees of difficulty, with an average difficulty rate of 60 percent. 1 reference.

81-1231
Social Psychological Factors in Adolescent Cigarette Smoking.
Sherman, S. J.; Chassin, L.; Presson, C. C.; and Olshavsky, R. W.
Paper presented at the Annual Convention of the American Psychological Association (87th, New York, N.Y., September 1-5, 1979), 12 p., September 1979.
Available from: ERIC; Order No. ED-184 014.

A 4-year longitudinal study of junior high and high school students is being undertaken that will use a time-sequential design to determine the social and psychological factors involved in cigarette smoking among adolescents. The study will measure attitudinal (beliefs about the consequences of a behavior) and normative (beliefs about how others view the behavior) components to determine the consistency between the two, and will attempt to predict the behavior of each subject. A second model that perceives adolescent problem behaviors as age-graded (i.e., behaviors that are acceptable for adults but not for children) will help to identify susceptibility to cigarette smoking during certain transitional periods of adolescence. The first model will be valuable in predicting behavior associated with the early stages of cigarette smoking, while the second model will be useful in predicting behavior associated with advanced cigarette smoking. In addition to these general models, adolescent smoking will be analyzed in terms of certain derivations from attribution theory (the perception of consequences and causes of smoking affect subjects' likelihood of smoking). These three models were tested with college students in a pilot study. Results of the study indicate that (1) female smokers

and nonsmokers perceived nonsmokers as having more positive traits than smokers; (2) a variety of behavioral intentions were predictable for smokers; and (3) smokers viewed their smoking as affected by situational control, whereas nonsmokers perceived more personal than situational control of their nonsmoking. 12 references.

81-1232
Warranted Uncertainty and Students' Knowledge and Use of Drugs.
Sieber, J. E., Clark, R. E.; Smith, H. H.; and Sanders, N.
Contemporary Educational Psychology 3(3):246-264, July 1978.

The ability to recognize situations in which uncertainty is warranted was developed effectively in 167 elementary school students through daily 15-minute lessons over a 5-week period. Though the initial training did not deal with drug use in any way, a 3-year followup evaluation measured retention of these warranted-uncertainty skills and assessed the effects of these skills on students' use of hard and soft drugs. In comparison with control subjects, experimental subjects demonstrated some retention of the skills after 3 years and were slightly better able to recognize situations in which uncertainty about the effects of drugs is warranted. However, there was also strong evidence that many of the controls had acquired the ability to generate warranted uncertainty, and that warranted uncertainty functioned as a stable construct (regardless of how it was acquired) and was related to drug use. The variable appeared to produce a skepticism or an analytical attitude that allowed the student to ignore peer and parental dogma about drugs. 10 references.

81-1233
"Quality of Oral Health Care."
Stein, L.
Journal--District of Columbia Dental Society 54(1):34-38, Summer 1979.

Since 1973, when the California Dental Association (CDA) formed the Task Force on Quality Evaluation, consisting of consumer representatives, practicing dentists, dental educators, dental insurance administrators, and State and Federal Government representatives, the accountability of dentists in maintaining high standards and meeting consumer needs has increased significantly. The task force defines the standards of quality for dental care and establishes the necessary measures or procedures in the dental quality control program. During its 3-year tenure, the task force published a manual on assessment of clinical quality and professional performance, developed dental insurance program standards, initiated a research study to determine the technological feasibility of using computers to identify poor providers, strengthened the CDA peer review system, and established a CDA consumer advisory board. Results of these efforts indicate that (1) coordinated and ongoing efforts between the profession and the public must be undertaken; (2) research activities must be supported; (3) insurance companies should be informed of dentist- and patient-identified priorities; and (4) nationwide quality assurance programs must be implemented. 3 references.

81-1234
Preliminary Results of a Picture Recognition Study Amongst Bangladeshi Women.
Tauber, I. J., et al.
Health Visitor (London) 53(7):251-253, July 1980.

A group of health and educational workers interviewed Bangladeshi women living in Tower Hamlets of East London, England, to determine the recognizability of 16 pictures intended for use in health education programs, and to assess the women's reading ability. The interviewers included two health visitors, two community doctors, a community nurse, a play teacher, and an adult education lecturer. Data from 133 interviews indicate that (1) use of color as opposed to black-and-white pictures aided correct identification of some of the items depicted; (2) drawings appeared to be easily identified; (3) a majority of the women could understand concepts underlying the pictures; and (4) 56 percent of the women could read Bengali and 11 percent of the women could read English. Results suggest that simple photographs or drawings of familiar objects can be recognized, the use of pictures in providing messages cannot be relied on without verbal reinforcement, and the reading ability of the women should be utilized in future programs by providing Bengali leaflets and pictures with subtitles. 1 reference.

81-1235
Task Analysis: Determining What Should Be Taught.
Thygerson, A. L.
Health Education 8(2):8-9, March-April 1977.

Adoption of the task analysis approach for health education would enhance curriculum development. A task is an action required to complete an objective that includes a number of tasks. The first step of task analysis, therefore, involves listing all the tasks that might be included to achieve an objective. Each task should be coded for frequency of performance, importance, and learning difficulty. An analysis of the behavioral steps involved in

performing each task follows. These steps should include recognition of optimal times to perform the task, selection of necessary materials, performance of appropriate procedures, and assessment of performance of the task. Instruments that can help educators and students to assess their performance of health tasks include the Fast-Tyson Health Knowledge Test available from Northeast Missouri State University; the Health Inventory available from the Department of Health and Safety of the University of Illinois at Champaign; the Status of Health Instructional Program form available from the Department of Health Education at Purdue University; the Health Instructional Emphasis form; the American Association for Health, Physical Education and Recreation (AAHPER) Cooperative Health Education Test (forms 3A and 4), available from Cooperative Tests and Services of Princeton, New Jersey; the "You Are a Decision-Maker" form available from the Lehigh Valley Area Health Education Center of Allentown, Pennsylvania; and the Health Behavior Inventory available from the California Test Bureau of Monterey, California.

81-1236
The Case for Preventive Nutrition.
Tougas, C.
Dimensions in Health Service (Toronto) 57(7):23-24, July 1980.

The Quebec Hospital Association formed a committee to offer suggestions for the improvement of dietary services and nutrition education within all hospitals in Quebec, Canada. Questionnaires covering all aspects of food preparation and service were sent to all hospitals in the Province. Data from the 115 returned questionnaires revealed that (1) 62 percent of the hospitals' specifications for food purchasing were determined by specialists such as dietitians; (2) such specifications were generally followed; (3) only 17 percent of the hospitals met the criteria of preventive nutrition; (4) 38 percent of the hospitals employed persons as dietitians who were not aware of preventive nutrition strategies; (4) food preparation was generally lacking in the area of fat removal, food temperature, and dessert ratings; (5) no well-defined preventive education program concerning nutrition had been established; (6) most people in charge of food preparation lacked formal education in this area. The committee recommends that (1) preventive education be incorporated into hospital dietary policies; (2) experts be in charge of purchasing and receiving food; (3) meals reach patients as soon as possible; (4) menus reflect nutritional guidelines; (5) inservice training in nutrition be provided to food service personnel; and (6) food evaluation questionnaires be administered to all patients.

81-1237
Accounting for Health Instruction.
Yarber, W. L.
Health Education 8(2):4-5, March-April 1977.

School health educators must choose appropriate evaluative instruments and procedures appropriate to the educational level and population characteristics of the target audience. A thorough health education evaluation involves student testing, instructional program evaluation, and parent and community input. An adequate test should assess the topics that students feel should be emphasized as well as students' knowledge and attitudes. During the instructional program evaluation phase, teachers and administrators should complete evaluative forms and questionnaires and discuss the health curriculum in conferences. Finally, parental and community participation in curriculum development ensures support for the program once it has been implemented.

81P-1238
Development of a Clearinghouse for Community-Based Health Education Programs.
Health Education Center of the Health and Welfare Planning Association, 200 Ross Street, Pittsburgh, PA 15219
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
September 1978 - January 1979.

The Health Education Center of Pittsburgh, Pennsylvania, contracted to conduct an analysis of data on over 1,500 contacts for consultation and technical assistance in the health education field. The analysis was designed to determine utilization patterns and alternatives for conducting a clearinghouse role for community-based health education programs. Specifically, the center was to analyze the utilization patterns of a health education center's inventories of materials, programs, and personnel over an 18-month period; review health education literature regarding provision of clearinghouse functions for comparison purposes; develop criteria for selection of materials for inclusion in inventories of a typical health education center; and develop recommended procedures and alternative actions for community-based health education programs. The Health Education Center submitted a final report containing an analysis of the organization's consultation and technical assistance services, a review of the literature and comparison of other health education center clearinghouse functions, and specific recommendations for establishment and operation of a health education center that provides a clearinghouse service.

81P-1239
Life Skills Training.
Botvin, G. J.
Cornell University Medical Center, Department of Public Heath, 411 East 69th Street, New York, NY 10021
Funding Source: National Inst. of Child Health and Human Development (DHHS, NIH), Bethesda, Md.
1979 - 1982.

The Life Skills Training program was established to test the effectiveness of a smoking prevention strategy that focuses on the social and psychological factors involved in the development of smoking among adolescents. A strategy which emphasizes the development of basic life skills and the improvement of personal competence is used in the program to prevent smoking onset. The program consists of a two-session cognitive component that focuses on the prevalence and effects of smoking, a two-session decision-making component that focuses on the decision-making process and techniques used by the tobacco industries and others to influence consumers, an anxiety-reduction component that focuses on specific skills and techniques, a four-session social skills training component, a one-session self-improvement component, and an 8-week self-improvement project. Teachers implementing the strategy attend a 1-day inservice workshop. Audiotapes and biofeedback techniques are used during the student program. A time-series design was developed to test the short- and long-term efficacy of the strategy for preventing onset of smoking with a population of 1,200 seventh graders from 8 schools in Nassau County, New York. All students were pretested with a 16-page questionnaire, and saliva samples were collected. Posttest data were collected on all students 3 months after the pretest. Data from the first year of the 3-year study indicated that the program reduced the level of smoking among smokers and the number of persons taking up smoking.

81P-1240
Measures of Diabetic Patient Knowledge, Attitudes, and Behavior Regarding Self-Care.
Rand Corporation, 1700 Main Street, Santa Monica, CA 90401
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
September 1977 - June 1979.

The Rand Corporation conducted a study designed to measure behaviors, attitudes, and knowledge amenable to change through patient education interventions, particularly related to nutrition, designed for diabetics. After delineating important behaviors, attitudes, and knowledge components associated with the control of diabetes, literature was to be searched for acceptable measurement techniques, and yet undeveloped measurement procedures were to be derived. The literature review was to encompass scientific journals, books, government reports, and hospital and medical school bulletins and reports. A comprehensive study of the reliability and validity of all measures found in these resources was to be undertaken. New measurement procedures developed by Rand after the literature review and comprehensive study were to be tested using experimental designs. A list of important behaviors pertinent to the control of diabetes, a list of measurement procedures found in the literature or developed subsequent to the review of the literature, a draft and final version of all activities and recommendations related to the study, and a complete set of copies of all articles and materials referenced in the final report were to be submitted.

81P-1241
Media Coverage of Events Relating to the Swine Flu Program.
University of Cincinnati, Cincinnati, OH 45221
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
March 1977 - June 1977.

The University of Cincinnati conducted a study designed to examine events that might be expected to influence public acceptance of the swine flu vaccination. A comprehensive chronology of events occurring between January 1976 and February 1977 that related to public acceptance of the vaccination was to be developed. The study was to consider not only events involving swine flu, but also other events, such as those related to the outbreak of Legionnaires' disease. Separate chronologies were to be developed for each of the four major regions of the country. Newspapers and magazines as well as other communications media were to be reviewed for information relating to perceptions and attitudes concerning swine flu and the vaccination. A narrative description of events related to the swine flu program in each of the four major regions was to be produced.

81P-1242
Public Attitudes Toward Immunization.
Opinion Research Corporation, North Harrison Street, Princeton, NJ 08540
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
August 1977 - March 1978.

"Public Attitudes Toward Immunization," a study conducted by Opinion Research Corporation, involved three nationwide attitude surveys, one each in September 1977, January 1978, and February 1978. Each survey was to involve a minimum of 2,000 respondents. Seventy-five percent of the respondents were to have children under 18 years old living with them, and 50 percent of these respondents were to be the medical decision makers in their families. Each national sample was to be stratified by geographic location and metropolitan versus nonmetropolitan residence. Survey questionnaires were to be designed to determine the relationships between past experience with immunization and the desire to receive, or have children receive, other immunizations and to establish base-line data regarding the desire to receive specific immunizations and beliefs about the threat of the disease and the safety and efficacy of various vaccines. Special emphasis was to be given to attitudes and beliefs concerning swine flu and the swine flu vaccine. Results of each survey, draft and final versions of a summary of the three surveys, and a computer tape with all respondent data and a coding booklet were to be produced.

81P-1243
Public Attitudes Toward the Swine Flu Immunization Program: Nine National Opinion Surveys.
Opinion Research Corporation, North Harrison Street, Princeton, NJ 08540
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
August 1976 - June 1977.

The Opinion Research Corporation conducted a project to determine public attitudes about swine flu immunization. The survey used was designed by Walter J. Gunn, Ph.D., Director, Research and Evaluation, Health Education Division, Center for Health Promotion and Education. The survey was adjusted to reflect changes in the country's demographic profile as established by the latest Bureau of Census estimates. The Opinion Research Corporation of Princeton, New Jersey, the administering organization, performed a series of attitudinal surveys, each of which contained at least 1,500 public respondents in order to reflect the demographic profile of persons over 18 years old in the country. The national samples were to be stratified by geographic region and metropolitan versus nonmetropolitan residence. Within each stratum, the selection of the ultimate sampling unit was to be determined by multistage cluster sampling. Interviews were to be conducted in a minimum of 100 different locations throughout the country and were to be conducted in the respondents' homes. The first survey was to be undertaken in August 1976. Monthly surveys were conducted in September, October, November, and December 1976 and in January, February, March, and April 1977. A new sample was to be drawn for each survey. Survey data were to be tabulated and summarized and perhaps added to other national surveys.

81P-1244
A Study of the Impact of the 1978-79 National Influenza Immunization Program on Specific Physician Groups.
Opinion Research Corporation, North Harrison Street, Princeton, NJ 08540
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
August 1979 - December 1979.

The Opinion Research Corporation conducted an evaluation of the 1978-79 National Influenza Immunization Program. Interviews were to be performed with at least 250 physicians from each of 4 groups, namely, general and family practitioners, internists, pediatricians, and industrial physicians. The pretested interview survey was to be administered over the phone or in person. Of the first 600 potential respondents, 200 were to be offered $25 to participate in the survey, 200 offered $50 to participate, and 200 asked to participate without provision of a fee. Subsequent attempts to recruit respondents were to be based on the results of this initial pretest of incentives. Within 8 weeks after the effective date of the contract, a draft version of a final report on survey results was to be submitted. The draft report was to cover the impact of the program on private sector physicians, current and past practices of physicians in regard to administration of influenza vaccines, attitudes and levels of knowledge of private physicians regarding influenza and immunization programs, number and types of adverse reactions experienced by patients, and effects of incentives on physician response rates. Data on physicians was to be tabulated according to the group to which each physician belonged, physician's race, size of practice, years in practice, geographic region in which the practice was located, type of community in which the practice was located, and racial makeup of patients. A revised version of the draft report was to be submitted as the final report within 12 weeks after the effective date of the contract. Within 16 weeks of the effective date of the contract, a computer tape of the survey data and a coding booklet were to be submitted.

81P-1245
1979 Immunization Survey.
Opinion Research Corporation, North Harrison Street, Princeton, NJ 08540
Funding Source: Center for Health Promotion and Educa-

tion (DHHS, CDC), Atlanta, Ga.
January 1979 - June 1979.

The Opinion Research Corporation conducted a study of 3,000 people during a 30-day period to determine public attitudes toward immunization. Under the study design, 75 percent of the respondents were to have children under 18 years old living with them; 75 percent of these respondents were to be the medical decision maker of the family; and 500 respondents were to be in Arkansas and 700 in California. The overall sample, stratified by geographic location and metropolitan versus nonmetropolitan residence, was to represent the population of the United States over 18 years old. Mathematical models were to be designed to predict intentions concerning vaccination and reported immunization histories based on elements such as demographic factors; immunization history; disease history; and knowledge of seriousness, preventability, curability, and likelihood of occurrence of a specified disease. The final report on the contract was to describe the background and objectives of the study, survey methods used, major factors associated with acceptance or nonacceptance of immunization, effects of the 1979 influenza immunization program, attitudes and beliefs of people at high risk for influenza, the level of knowledge of the public regarding specific diseases, perceived immune status of women with regard to rubella, and the accuracy of immunization records kept by parents and physicians. A code book and computer tape of all respondent data were to be produced.

RISK REDUCTION

81-1246
Dental Health Education for Mothers of Pre-School Children.
Coutts, L.
Midwife, Health Visitor and Community Nurse (London) 16(8):328-331, August 1980.

An effective dental health education program aimed at mothers in the United Kingdom is described. The program includes strategies to promote maintenance of low cariogenic diets for preschool children, control of plaque by brushing and other mechanical means, adoption of periodic preventive visits to the dentist, systemic or topical applications of fluoride, and a belief that losing teeth is not inevitable. 14 references.

81-1247
Boys' Clubs of America Alcohol Abuse Prevention Project, 1977-78: Final Evaluation.
Insight Associates, Great Neck, N.Y.
New York, Boys' Clubs of America, 57 p., December 30, 1978.

The Boys' Clubs of America has received a 3-year grant from NIAAA to develop a model prevention program (Boys' Clubs of America's National Alcohol Abuse Prevention Program) to reduce alcohol abuse among young people. The program aims at educating youngsters about alcohol use, enabling youngsters to make responsible decisions about alcohol, developing leadership potential and peer role models for youth, training Boys' Club professional staff, distributing prevention materials, replicating models developed and tested during 1975 to 1976 and 1976 to 1977, and incorporating a continuing alcohol abuse prevention program into the national organization. Evaluation of the program's third year involved assessment of program replication and provision of feedback to program administrators at the national level. Rating sheets completed by project coordinators and interviews of coordinators by evaluators constituted the major evaluation tools. The seven Boys' Clubs offering programs focused on media approaches, arts and crafts, peer leadership, peer consulting, values clarification, and cultural examination strategies. The evaluation data indicated that (1) all seven prototype models are amenable to incorporation into a Boys' Club program; (2) future target audiences should be more specifically identified; and (3) the manual developed during the program is an excellent resource.

81-1248
Boys' Clubs of America Alcohol Abuse Prevention Project, 1976-77: Final Evaluation.
Insight Associates, Great Neck, N.Y.
New York, Boys' Clubs of America, 59 p., August 15, 1977.

The Boys' Clubs of America National Alcohol Abuse Prevention program, which completed its second year in June 1977, aims at enabling youngsters to make responsible decisions concerning alcohol and at developing replicable model alcohol education programs that can be incorporated into a Boys' Club framework. Program evaluation involved listing program objectives, developing a series of individual rating sheets, and conducting a series of structured interviews with project coordinators. Individual model projects evaluated included programs in central Florida; East Aurora, New York; Fullerton, California; Bronx, New York; Pacifica, California; Pittsfield, Massa-

chusetts; Richmond, California; South Omaha, Nebraska; and Wheeler, Indiana. Various programs focused on values clarification, peer counseling, public service techniques, cultural exploration strategies, media projects, community education, arts and crafts, and family approaches. On the basis of the evaluation, it is recommended that (1) the self-monitoring aspect of behavioral objectives be clarified; (2) all staff members be briefed in advance on the nature of the program; (3) some clubs experiment with short-term intensive programs; (4) prevention models be built into the clubs' physical education and summer camp programs; (5) workshops and training on program development be implemented; (6) guidelines on maintaining relations with local agencies be developed; and (7) inclusion of young alcohol abusers in appropriate programs be encouraged.

81-1249
Nutrition Intervention Strategies in the Multiple Risk Factor Intervention Trial (MRFIT).
Mandriota, R.; Bunkers, B.; and Wilcox, M. E.
Journal of the American Dietetic Association 77(2):138-140, August 1980.

The Multiple Risk Factor Intervention Trial (MRFIT), which is currently underway and scheduled to end in 1982, intervenes simultaneously in regard to three major risk factors--cigarette smoking, hypertension, and elevated serum cholesterol. The MRFIT strategy involves small group sessions of participants, their homemakers, and two or three specialists, including a nutritionist and a smoking specialist, to discuss personal and environmental factors that interfere with patient adherence to rehabilitation regimens. Behavioral self-monitoring tools, including food diaries, smoking records, and the Food Record Rating which provides immediate feedback on the participants' food patterns, were used to identify problem areas, to develop problem-solving skills, and to provide immediate feedback on progress. Educational materials and audiovisual aids developed to facilitate the transfer of basic information included a cookbook published by the American Heart Association; a list of foods compatible with the fat-controlled, low-cholesterol regimen; and four nutrition slide-tape units with accompanying brochures. The intervention staff meets weekly to discuss each participant's progress, and additional interventions are planned for those who have not reached their risk reduction goals at the end of the 8- to 10-week program. Participants who have reached their goals are seen every 4 months for risk monitoring. 5 references.

81-1250
Prevention--Today's Dietary Challenges.
McGinnis, J. M.
Journal of the American Dietetic Association 77(2):129-132, August 1980.

The history of eradication of the major infectious diseases and of control efforts aimed at major chronic diseases testifies to the role of preventive nutrition education in improving the health of people living in the United States. A historical study of the decline of infectious diseases in England revealed that this trend began before the development of immunization and proper sanitary measures, indicating that it can be attributed to the improvement in the nutritional status of the people because of economic prosperity. Similar studies in Africa and the Middle East corroborate this view. A panel of nine senior scientific members of the American Society for Clinical Nutrition felt the most important nutritional issues are the relationships of alcohol to cirrhosis; carbohydrates to caries; salt to hypertension; cholesterol and saturated fats to heart disease; and excess calories to diabetes, hypertension, and heart disease. In the area of education and health promotion, nutritionists and dietitians should (1) take advantage of the increasing number of fast food outlets, which can be used for health promotion; (2) work with supermarkets to maximize information provided to the consumers in the store; (3) accommodate the needs and habits of those who live alone, particularly the elderly; and (4) incorporate the use of health risk appraisals, video discs for family and classroom instruction, and television and radio public service announcements. 18 references.

81-1251
A Comprehensive Television Smoking Cessation Programme in Finland.
Puska, P.; Koskela, K.; McAlister, A.; Pallonen, U.; Vartiainen, E.; and Homan, K.
International Journal of Health Education (Geneva) 22(4, Suppl):1-28, October-December 1979.

A smoking cessation course arranged by the North Karelia Project and Finnish television was presented on television in North Karelia in February and March 1978 and again in spring 1979. During the month prior to the initiation of the program, a promotion campaign was implemented that included a national press conference, several articles in the printed media, daily spots on television, and publicity efforts by health centers associated with the National Board of Health and by voluntary public health organizations. The 4-week course consisted of 7 sessions during which 10 smokers and 2 experts participated in the smoking cessation program. The effects of the program were

assessed via pre- and postprogram mail surveys, followup surveys, documentation from organized cessation groups in North Karelia and control groups from a matched reference county, a mail survey of lay group leaders in North Karelia, and documentation of the newspaper articles on the program. Results of these evaluation efforts indicate that (1) most smokers wish to stop, (2) use of the mass media to administer smoking cessation programs in combination with group activity in the field can be almost as effective as face-to-face programs, and (3) the costs of such programs are low. 28 references.

81-1252
The Effects of a Heart Health Education Workshop.
Wolfgang, J. and Dennison, D.
Journal of School Health 51(5):356-359, May 1981.

A study was undertaken to develop and evaluate the effectiveness of a 6-hour inservice workshop emphasizing that teachers must be motivated to improve their own heart health behaviors to be successful in modifying the behavior of their students. The 17 high school teachers attending the workshop measured their height, weight, skinfold, blood pressure, cardiovascular endurance, dietary intake, smoking behavior, and serum cholesterol levels and lipid ratios. The participants concentrated on the knowledge and affective information necessary to improve heart health behavior and were asked to improve their own heart-related behavior. The western New York chapter of the American Heart Association (AHA) awarded participants with a certificate for successful completion of the workshop. A controlled experiment involving the 17 participants, 176 of their students, and 66 students of teachers who had not participated was undertaken to assess the ability of the participants to implement an 18-hour heart health course developed by the AHA. Students were evaluated via self-report and biomedical data before, immediately after, and 5 weeks after the course. Only students whose teachers had attended the workshop showed an improvement in the means of total cholesterol, high-density lipoprotein, ratio of total cholesterol to high-density lipoprotein, and carbon monoxide. They also reported a decline in saturated fat intake. 14 references.

81P-1253
"Food for Thought" Nutrition Education Program.
Temple, H.
University of Rhode Island, University Health Services, Health Education Department, Roosevelt Hall and Potter Building, Kingston, RI 02881
Funding Source: Center for Heath Promotion and Education (DHHS, CDC), Atlanta, Ga.
Continuing.

The "Food For Thought" Nutrition Education Program at the University of Rhode Island provides nutrition education and helps students lose weight. Services offered by the program include educational workshops, diet counseling, films on exercise and weight control, and food demonstrations. In addition to individual instruction and group support services, the program offers a resource library and a weight control center. Approximately 2,000 students are served each year. The program is staffed by a graduate assistant, an undergraduate intern, and three to five undergraduate or graduate volunteers.

81P-1254
American Public Health Association Health Education Program.
American Public Health Association, 1015 15th Street, N.W., Washington, DC 20036
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
January 1975 - August 1977.

The American Public Health Association Health Education Program was to develop a health education program for its membership, regional and local counterparts, and sections of the association. The American Public Health Association, the administering organization, emphasized smoking and health, cancer and heart and lung diseases, and preventive measures for groups at high risk. The program included activities for continuing education for public health professionals, school health programs, and cooperative work with other national organizations active in health education. Specifically, the association was to establish a project advisory committee of five to eight representatives of association sections and professional educators that was to meet twice each year to direct and oversee the project. Four geographic areas were selected for intensive work, involving formation of a nucleus group to develop a pilot prevention project among health workers and provision of technical assistance and support to these participating bodies. Evaluation procedures were established to assess the project's impact on professionals and occupational settings. In addition, the association incorporated primary prevention education into the sessions at the national, regional, and State meetings of the association; developed prototype educational materials to emphasize the importance of health professional participation in public health education activities; conducted educational and informational smoking prevention through special programs and professional periodicals; maintained working liaisons with several national organizations interested in controlling smoking and other high-risk practices; and developed a plan to extend and improve health education leadership and support to public

health workers. Quarterly progress reports, the plan for public health workers, and a final report were to be delivered during the project period.

81P-1255
CHEARS (Campus Health Education Alcohol Resource Services).
Temple, H.
University of Rhode Island, University Health Services, Health Education Department, Roosevelt Hall and Potter Building, Kingston, RI 02881
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.; National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.
September 1975 - Continuing.

CHEARS (Campus Health Education Alcohol Resource Services) provides alcohol information and counseling services to alcohol-troubled students and contributes to environmental changes that will reduce risks of alcohol-related problems. The program offers peer counseling, workshops, a resource library, a drop-in center, a hotline, alcohol education films, lectures on alcohol-related problems, and a referral service. Selected students receive one semester of credited training to enable them to provide information and support for students with alcohol-related problems. Approximately 3,000 students use the program services annually. The program is staffed by an alcohol educator, an alcohol counselor, a secretary, and 20 student volunteers. The program maintains a contractual liaison with Sympatico, a local community service agency. Records are kept on student usage, and peer counselors are evaluated with pre- and posttraining questionnaires.

81P-1256
CPR Program.
Saccoccia, S.
University of Rhode Island, University Health Services, Health Education Department, Roosevelt Hall and Potter Building, Kingston, RI 02881
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
September 1979 - Continuing.

The Cardiopulmonary Resuscitation (CPR) Program at the University of Rhode Island is designed to train all interested students, staff, and faculty in CPR techniques. Each year, the program offers a three-session, 9-hour training program, which attracts 300 to 500 participants. The staff includes a student coordinator and three student volunteers. Records are kept on the number of persons who qualify for CPR certification each year. The program is financed through the university's health services budget.

81P-1257
Healthy Heart Program--Eating and Your Heart.
Anderson, J.
Colorado State University, Cooperative Extension Service, Food Science and Nutrition Extension, 310 Gifford Building, Fort Collins, CO 80523
Funding Source: Colorado Heart Association, Denver, Colo.
1978 - Continuing.

The Healthy Heart Program (Eating and Your Heart) is a risk reduction program delivered to the general public through trained local professionals and the Food Science and Nutrition Extension Service of Colorado State University. The community-based program offers heart health classes that emphasize nutrition. State extension agents and public health nurses identify needs of communities or regions, define target groups and localities, and adapt the program to the specific needs of each group. The target audience consists of high-risk individuals reached via cardiac rehabilitation units, hospitals, and public notices. Local trainers are chosen on the basis of recommendations by extension agents and trained in basic concepts of nutrition, dietary analysis, and presentation of educational materials for lay audiences. Local program leaders may be health educators, nurses, nutritionists, or dietitians. Classes offered by trainers involve assessment of participants' physiological and nutritional status, instruction in self-monitoring skills, and dissemination of a consumers guide. The program forms the educational component of a hypertension control project being conducted by the Colorado State Department of Health. Each course is assessed via pre- and postprogram questionnaires, satisfaction questionnaires, followup questionnaires, body assessments, and computer diet analysis for 10 percent of the participants.

81P-1258
Healthy Lifestyle Programs.
Turner, D. A.
San Francisco Department of Public Health, Room 204, 101 Grove Street, San Francisco, CA 94102
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1980 - Continuing.

The Healthy Lifestyle Programs of the San Francisco Department of Public Health are designed to reduce chronic disease risk factors through identification of these risk fac-

tors and through risk reduction interventions. Services include health hazard appraisals, smoking cessation clinics, stress management clinics, nutrition and weight control clinics, and hypertension screening and education programs. Individual assessment via the health hazard appraisal instrument provides base-line information for development of intervention plans for risk reduction. The programs are provided through business and labor organizations. In addition to providing direct services, the Department of Public Health staff trains organizations in the development, provision, and evaluation of health hazard appraisal and risk reduction programs. Individuals from other county health departments in the State are also trained in program implementation techniques. The programs aim to serve 2,500 individuals during the project year and to reduce chronic disease risk factors among the target population by 30 percent. The 2,500 individuals include 500 city and county employees, 1,000 employees of local businesses or members of local labor unions, and 1,000 college students. The program is staffed by a director with a master's degree in public health administration and planning, the chief of the Bureau of Health Promotion and Education, an associate director, a public health nurse, a management trainer, and an administrative assistant. The Healthy Lifestyle Programs provide aggregate analysis of the data, which can be used as a tool for health program planning and as a method of monitoring changes in risk and risk-related behaviors over time.

81P-1259
Hypertension Control Program.
Coyne, M. C.
Brockton Visiting Nurse Association, 300 Battles Street, Brockton, MA 02401
Funding Source: Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
January 1981 - Continuing.

The Hypertension Control Program is designed to provide worksite educational sessions and blood pressure screening at no cost to Brockton, Massachusetts, industries. Working with personnel departments, the program detects and refers hypertensive individuals. Interested businesses must provide space and allow employees time for screening, maintain strict confidentiality of all medical data, and guarantee that employees' jobs will not be jeopardized by their participation in the program. One week prior to screening, an educational program is provided at the worksite to instruct employees in the basic facts concerning high blood pressure and to encourage participation in the screening program. For those hypertensives with a previously established source of care, referral and treatment is continued by their private physician or health center. For individuals without a prior source of medical care who require further evaluation, referral will be made to local physicians who have agreed to take new referrals. Program staff are seeking assistance from Brockton-area associations and organizations to communicate the availability of the program. Materials dealing with the format, which also may be used in newsletters and on bulletin boards, have been sent to local organizations, and the local newspaper has published an article explaining the program to Brockton residents. Massachusetts State data forms are used to secure monthly program statistics for future evaluation.

SCHOOL HEALTH EDUCATION

81-1260
Evaluation of Three Approaches to Changing Dental Hygiene Behaviors.
Albino, J. E.
Journal of Preventive Dentistry 5(6):4-10, November-December 1978.

A study of 171 seventh-grade students in 3 schools in Buffalo, New York, was designed to assess the efficacy of a dental health education program using behavioral rehearsal as the central technique. The subjects were divided into (1) a control group, (2) an instructional group that participated in two instructional sessions conducted by a dental assistant, (3) a group that received the instructional intervention and participated in two motivational sessions, and (4) a group that participated in the instructional and motivational sessions that included mental rehearsals of routine dental hygiene techniques. The motivational sessions for the third group involved relating good dental hygiene to the students' personal values and suggesting techniques to improve dental hygiene. Each student received a base-line assessment involving plaque scores and gingival indices and a similar postprogram assessment 24 weeks later. The assessments included clinical examinations and photographic assessments. Data was analyzed via one-way multivariate analysis of covariance performed with five dependent variables and three covariates. Results of data analysis indicated that dental care behaviors could be changed through procedures that focus on inconsistencies between expressed beliefs and actual behaviors, but that the magnitude of changes obtained in this study reflected only limited clinical impact, particularly considering the amount of effort expended on counseling members of the third and fourth groups.

81-1261
In-Service Education of Teachers: Radical Alternatives to Traditional Approaches.
Cowley, J.
International Journal of Health Education (Geneva) 22(4):227-231 1979.

In response to the perceived ineffectiveness of teachers in implementing the Schools Council Health Education 5-13 Project, the British Health Education Council commissioned TACADE (an organization for teachers that provides inservice training) to write an inservice training program for the teachers of children 5 to 13 years old. Research prior to development of the program included a review of school records using the curriculum material, meetings with teachers, and a review of project evaluation results for schools using the curriculum. A workshop manual was devised which addressed problems identified during the research phase, including reluctance to carry out sex, drug, and alcohol education for children under age 11, and a number of other issues related to planning. The workshop program, which was preceded by an intensive education and teacher observation period, included sections on curriculum review, key concepts in health education, and curriculum development. With the aid of one or two senior staff members, who attend a course and work through the manual, the workshop can be presented to any school teaching staff. This program and a similar program for high school classes are currently being studied using several different evaluation designs. 7 references.

81-1262
Games and Audiovisual Aids in Preadolescent Nutrition Education.
Cuffaro, C. and Shymko, D. L.
Journal of Nutrition Education 12(3):162-164, July-September 1980.

A study of 76 sixth grade students enrolled in 2 elementary school classes in a large city in eastern Canada assessed the effectiveness of a nutrition education unit for preadolescents and compared the value of active student activities with that of passive student activities. The two classes were presented the same nutrition information by lecture and completed the same dietary record assignment. One class also actively participated in a variety of competitive word and board games, while the other class was presented with audiovisual materials. A third class served as a control, receiving no nutrition education information. Pre- and posttests were administered to all three classes and indicate that, compared with the control group, both of the experimental groups experienced a significant gain in nutrition knowledge. However, no significant differences were found between the two experimental groups. Under the conditions of this study, the use of student participation approaches demonstrated no advantage over the use of audiovisual aids, a passive educational approach. 10 references.

81-1263
The Effects of Educational Intervention and Parental Support on Dental Health.
Hart, E. J. and Behr, M. T.
Journal of School Health 50(10):572-576, December 1980.

The feasibility and effectiveness of a school-based dental health education program that included a parental-support component was studied using 134 12-year-olds enrolled in 2 dissimilar public schools. One of the schools served a rural area and the other served both suburban and rural areas. Students from both schools were assigned to a group that received an eductional intervention with a parental-support component, a group that received an educational intervention without a parental component, or a control group. Data were collected after the interventions using the Tennessee Dental Health Achievement Test and the Lundh Dental Health Education Inventory. Responses of parents visited by hygienists as part of the parental-support component were recorded by the hygienists on a structured form, and each parent visited was called 1 week after the visit to ascertain general reactions. Posttest data indicate that (1) dental health knowledge and attitudes increased for both treatment groups, but not for the control group; (2) knowledge gains did not deteriorate over a 2-month followup period for the group receiving parental intervention, though gains did deteriorate for the experimental group; and (3) females seemed to be more receptive to the program than males. 18 references.

81-1264
Southwest Georgia School Health Education Evaluation.
James, S. E.
Albany, Ga., Southwest Georgia Health Systems Agency, Inc., 51 p., August 1978.
Available from: NTIS; Order No. HRP-0028706.

Responses to a questionnaire sent to 204 public school principals and 34 private school headmasters in southwest Georgia indicated that current health instruction was inadequate. The two-part questionnaire designed by health systems agency (HSA) staff and a consultant assessed opinions and attitudes regarding health education.

The questionnaire requested information on the organization and administration of programming, the number of discrete courses, the number of integrated courses, the number of combined courses, incidental instruction, health instruction programming, and health instruction personnel. Data indicated that programs are almost always taught and planned by individuals who are not certified as educators. Sex education, noncommunicable diseases, and family life education are largely ignored. Funds and quality textbooks are lacking, and the schools are frequently not in compliance with State requirements for health education. To remedy the situation, the southwest Georgia HSA recommended that a public information campaign be developed to promote health education through parent-teacher associations, radio and television, and newspapers, and that a model program be developed in a rural and an urban school system to demonstrate how such a program might work. The program could be extended to all other schools in the area. An appendix tabulates the responses to the questionnaire. 6 references.

81-1265
Education for Aging.
McPherson-Turner, C.
Journal of School Health 50(6):314-317, August 1980.

A review of the basic concepts and generalizations related to aging illustrates means by which the content can be integrated into existing health curricula. Goals of education for aging within the health curriculum include promotion of individual responsibility for maintenance of good health; delineation of health practices that will prolong life; integration of social, emotional, and physiological growth and development throughout life; provision of opportunities for individuals to value their individuality; and promotion of an appreciation of the value of living longer. Curricular components into which aging topics can be integrated include the social nature of health, nutrition, physical fitness, mental and emotional health and disease, heredity and eugenics, chronic and degenerative diseases, physiological alterations during aging, family health and sexuality, and community health services. The relation between each concept and particular topics can be established via questions, which also provide the educator with a means of evaluating the effects of the curriculum. Latent values contained within the curriculum must be identified so that values conducive and inimical to the aging process can be analyzed. 9 references.

81-1266
Tobacco Education Curriculum: Senior High. Health Education: Substance Abuse Prevention.
New York State Education Dept., Albany. Bureau of Drug Education.
Albany, N.Y., the Department, 85 p., 1979.
Available from: ERIC; Order No. ED-180 987.

Guidelines for implementing a smoking education curriculum for senior high school students are offered for use by teachers and administrators. The curriculum contains a sampling of teaching methods, concepts, and objectives for the course as well as instructional units. Each unit, which reinforces a particular concept about smoking, includes suggested learning activities and instructional materials and resources available to the teachers. Concepts addressed by individual units include psychological and social influences on smoking-related decisions, health problems associated with smoking, economic and political implications of controls on tobacco products, and smoking cessation methods. Factsheets and worksheets are included. Appendices include listings of American Cancer Society county unit offices and New York State offices of the American Heart Association and the American Lung Association.

81-1267
Nutrition Knowledge and Interest Questionnaire (Test Booklet, Answer Sheet, and Teacher's Test-Administration Manual).
Passwater, G. D.
New York, Teachers College Press, 3 pieces, 1981.

An instrument to assess the nutrition knowledge and interests of high school students is provided, along with guidelines for use by instructors using the questionnaire. The portion of the questionnaire that assesses knowledge consists of 50 items, while the portion of the questionnaire that assesses interests consists of 5 items.

81-1268
The Life-After-Death Phenomenon.
Richardson, G. E.
Journal of School Health 49(8):451-453, October 1979.

The life-after-death phenomenon has created student interest, which can be developed advantageously by the informed health educator. Discussion of life after death is particularly challenging because of the shortage of data-based research to support or negate the possibility, the religious issues involved, and possible biases held by the educator. Several researchers have compiled some mutually reinforcing and overlapping information from case studies of those who were revived after medically dying and from cross-cultural comparisons of near-death experiences. The common factors in most of the case studies with important implications for health education include the patients' enjoyment of the death experience, the new

zest for living exhibited by patients who have been near death, and the lack of desire among such patients to take their own lives. Descriptions of the common experiences of the dying and of the complacence of those who have been near death may help students cope with the fear of the unknown involved in dying. Discussion of the life-after-death phenomenon can also help dissuade potential suicides and supplement debates over the validity of "living wills." Students involved in such discussions have reacted favorably. 7 references.

81-1269
From Classroom to Cafeteria...A Nutrition Guide for Teachers and Managers.
Sloan, S.
Atlanta, Ga., Food Service Program, Fulton County Schools, 160 p., April 1978.

Guidelines are presented to help school nutrition managers working with classroom teachers promote sound nutrition education for schoolchildren. The services of the manager strengthen the team approach that is necessary for a successful nutrition education program. The recommendations in the guidelines have been tested in Fulton County, Georgia, schools. The guidelines cover roles and responsibilities of the school nutrition director and the school nutrition manager, classroom and cafeteria activities, models for experimentation, handouts for teachers, promotion of eating green vegetables, nutrition activities, food habit surveys, a breakfast and lunch program, international menus, overuse of sugar, and classroom projects. Various programming materials are appended. 34 references.

81P-1270
Elementary School Health Curriculum Model Development Program.
Kanawha County Board of Education, 200 Elizabeth Street, Charleston, WV 25311
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1974 - 1977.

The Elementary School Health Curriculum Model (Berkeley Model) Development Program was to establish and maintain a training and support center with staff and resources to extend the curriculum into the Kanawha County, West Virginia, School District. The fifth, sixth, and seventh grade phases of the model covered the lungs and respiratory system, heart and circulatory system, and brain and nervous system, respectively. The Kanawha County Board of Education of Charleston, West Virginia, the administering organization, was to perform specific activities including formation of an advisory committee composed of administrators and teachers; provision of 10 days of training for at least eight five-member teams of educators to enable them to implement the model; development of a system for selecting trainee teams from districts in the region and no more than three out-of-State areas; provision of teaching materials to team teachers, including teaching models, audiovisuals, texts, and pamphlets; supervision of each team; sponsorship of a 1- to 2-day followup session for all teams to discuss and evaluate the model; maintenance of liaisons with parents, community officials, and voluntary State and community organizations; development of a project evaluation plan; and maintenance of liaisons among advisory committee members and training staff, the project officer and the officer's staff resources, and the Berkeley Project staff. Progress reports were to be delivered 30 days after the effective date of the contract, 30 days after the training sessions, and 6, 9, and 12 months from the effective date of the contract. A draft of the final report was to be delivered 60 days prior to the expiration date of the contract, and a final report was to be delivered on or before the expiration date of the contract.

81P-1271
Elementary School Health Curriculum Model Demonstration Program.
Cajon Valley Union School District, P.O. Box 1007, 189 Roanoke Road, El Cajon, CA 92022
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, GA.
1974 - June 1976.

The Elementary School Health Curriculum Model (Berkeley Model) Demonstration Program, conducted by the Cajon Valley, California, Union School District, was designed to establish and maintain a demonstration training and support center to incorporate the model into the curricula of the school district and region. The model consisted of three 8- to 10-week units of intensive study, one unit each for the fifth, sixth, and seventh grades. Each unit concentrated on one body system and all that affects it. Inservice training for educators involved 2 weeks of in-depth training of teams of classroom teachers and administrators; each team consisted of two teachers, a principal, and one to two curriculum support personnel. The school district was to establish an advisory committee of administrators and teachers to oversee the project; train at least six teams during 60 hours of inservice workshops; provide each team with all needed materials for implementation of the units; maintain close supervisory contacts with all teams; sponsor a followup evaluation session

for all trainee teams; provide interpretive activities for parents, official and voluntary State and community organizations, and other interested individuals; evaluate the project's impact on teachers, students, and parents; and involve at least one teacher training institution in appropriate activity associated with the model. Training and support activities for out-of-State teams on any one of the curriculum units may have been conducted as well. A review of workshop plans, three progress reports, and draft and final versions of a summary of all project activities was to be submitted.

81P-1272
Elementary School Health Curriculum Model Demonstration Program.
Seattle School District No. 1, 815 Fourth Avenue, Seattle, WA 98109
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1974 - June 1976.

The Elementary School Health Curriculum Model (Berkeley Model) Demonstration Program, conducted by the Seattle, Washington, School District No. 1, was designed to establish and maintain a demonstration training and support center to incorporate the model into the school district and community. The district would also provide training and programming resources to other teams of educators in the Northwestern United States. The sequential curriculum consisted of one 8- to 10-week unit each for the fifth, sixth, and seventh grade levels. Each unit concentrated on one body system and all that relates to it. Teacher training for the model involved 2 weeks of indepth instruction for teams of four or five school personnel, including two teachers, a principal, and one or two curriculum support personnel. The Seattle program was to establish an advisory committee of administrators, teachers, and other community representatives to oversee the project; train at least six teams, including as many as three out-of-State teams, during a 10-day period; provide necessary materials, lists of resources, and guidance to the teams; monitor trainee teams during onsite visits; sponsor a 1- to 2-day followup meeting about 9 months after the training session; provide interpretive services for parents, official and voluntary State and community organizations, and interested individuals; and develop a practical project evaluation design to assess the responses of teachers, their pupils, and the pupils' parents. Progress reports were to be submitted 1, 6, 9, and 12 months after the effective date of the contract and 30 days after the training session. Draft and final versions of an overall project report were to be submitted 60 days prior to the contract expiration date and on or before the expiration date, respectively.

81P-1273
Elementary School Health Curriculum Model Demonstration Program.
Board of Trustees, University of Illinois, Urbana, IL 61801
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1974 - June 1976.

The Elementary School Health Curriculum Model (Berkeley Model) Demonstration Program, conducted by the University of Illinois Board of Trustees, was designed to establish and maintain a demonstration training and support center to incorporate the model into the teacher training curriculum of the health education program of the university and into the curriculum development efforts of one local and at least two additional school districts. The model for fifth, sixth, and seventh grade students included curriculum components on the lungs and respiratory system, heart and circulatory system, and brain and nervous system, respectively. The board was to establish an advisory committee to oversee operation of the project; provide or assist in the acquisition of training resources; conduct inservice training in the model in one local school district to train at least four teams of five school personnel each; develop a system for selection of trainee districts; monitor trainee teams to assure adherence to the curriculum model; sponsor a 1- to 2-day session for trainee teams approximately 9 months after the first training session; conduct interpretive activities for parents, official and voluntary State and community organizations, and interested persons; and develop a practical project evaluation plan. Progress reports were to be submitted 2 months, 4 months, and 8 months after the effective date of the contract, and copies of all materials reproduced pursuant to the project were to be submitted.

81P-1274
Elementary School Health Education Curriculum Evaluation Project.
Education and Public Affairs, National Clearinghouse on Smoking and Health, 1853 K Street, N.W., Suite 500, Washington, DC 20006
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
1974 - February 1975.

The Elementary School Health Education Curriculum Evaluation Project was designed to conduct a longitudinal study of the impact of the curriculum on the attitudes and behavior of teenage students. The sample population was to consist of students in five school districts that had used the curriculum since 1969. The controlled study was to use the teenager's self-testing kit as well as a brief ques-

tionnaire designed to elicit demographic information on the students. Scores of curriculum participants and nonparticipants were to be compared to national norms. A 1-day training session was to be held for persons at each site responsible for collecting data, and technical assistance on the administration of the kit was to be provided to site personnel. Reports were to be submitted on data collection and sampling methods, the training session syllabus, data analysis methods, and the overall project and its results.

81P-1275
Learn About Smoking Pro and Con.
van Boer, H. and Rosado, O.
Vintage High School, 1375 Trower Avenue, Napa, CA 94558
September 1980 - Continuing.

"Learn About Smoking Pro and Con," the smoking prevention program at Vintage High School in Napa, California, is a minicourse designed to (1) provide scientific information about the effects of smoking, (2) determine the effect of personality traits on smoking cessation efforts, (3) provide individuals with information on how to quit smoking, and (4) provide information on the role of community health organizations vis-a-vis smoking problems. The 3-week minicourse, which was integrated into a biohealth class in the fall of 1980, included lectures, films, readings, laboratory experiments, creation of posters, and personal interviews and surveys. The course was offered to 150 high school science students. The staff, a physiology instructor and a career director, coordinate their activities with the Napa City Cancer Society, the St. Helena Hospital Outreach Program, and the Napa Seventh-Day Adventist Church 5-Day Plan for Smoking Cessation. Effects of the program were assessed with a postcourse test, a subjective evaluation questionnaire, a subjective evaluation formulated by the teacher and codirector based on student behavior and test results, and subjective evaluations by guest lecturers. Data from the student evaluation instruments indicated that (1) 59 percent of the students found the course very helpful, (2) 59 percent gained information that will enable them to help others, (3) 90 percent were convinced that smoking is harmful, (4) 73 percent wanted the course to continue, and (5) 70 percent talked with others about the course.

81P-1276
Life!
Saccoccia, S.
University of Rhode Island, University Health Services, Health Education Department, Roosevelt Hall and Potter Building, Kingston, RI 02881
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
September 1979 - Continuing.

The "Life!" program of the Health Services Department at the University of Rhode Island is designed to increase student awareness of the impact personal behavior has on health status and to provide referral and support for those who wish to make positive changes. The program sponsors health assessment workshops and health festivals that address emotional and environmental factors affecting health such as feelings, exercise, stress levels, rest and relaxation, and heredity. Trained student volunteers conduct the workshops and provide support and referral services. Classroom lectures or informal educational sessions and social events also can be arranged. The staff consists of one assistant health educator, who works part time, and 10 to 20 student volunteers who are trained in a health course. Records are kept on student participation in workshops and at health festivals; 1,000 students are served annually. Student interns are evaluated with questionnaires before and after their training program.

81P-1277
Say It With Puppets.
Kotowski, J.
Say It With Puppets, Box 24, Suffield, CT 06078
1974 - Continuing.

The Say It With Puppets program is an affective education program for 8- to 10-year-olds and is designed to supplement curricular programming. The program uses the children's own play-acting, coloring, and singing skills to instill basic concepts of self-esteem. The program kit features 32 two-dimensional puppets, 6 scripts, and a teacher's guide. Audiocassettes that accompany the plays are available in Spanish and English. The theme of the three-page playlets include the meaning of family membership, the difference between the use and abuse of drugs, dealing with the death of a loved one, and sensitivity to the feelings of others. The children construct the puppets from materials provided in the kits and work out interpretations of the characters' lines during enactment of the playlets.

81P-1278
School Health Curriculum Project (SHCP) Demonstration Program.
Atlanta Public Schools, 224 Central Avenue, S.W., Atlanta, GA 30303
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1975 - December 1976.

The School Health Curriculum Project (SHCP) Demonstration Program, conducted by the Atlanta Public School System, was designed to maintain a demonstration training and support center to incorporate the SHCP into the city's school system. The curriculum model consisted of four intensive units of study, one each at the fourth, fifth, sixth, and seventh grade levels. Each of the 8- to 10-week units was organized around a body system and all that relates to it. Inservice teacher training for implementation of the model involved 60 hours of indepth workshop instruction for interdisciplinary teams of educators; the teams consisted of two classroom teachers, a school principal, and one or two curriculum support personnel. Project personnel were to provide training in the sixth grade unit for several teams, including at least two teams from outside districts; emphasize districts capable of providing their own financial support; and establish an advisory committee with representatives from the State education agency, the higher education agency, the Comprehensive Health Planning Group, the Parents and Teachers Association, voluntary health organizations, and local school districts. The project staff were to submit quarterly progress reports, a brief account of plans for training workshops and State agency involvement, lists of proposed trainee districts, and draft and final summaries of all project activities.

81P-1279
School Health Curriculum Project (SHCP) Demonstration Program.
School District No. 12, Adams County, 10280 North Huron Street, Denver, CO 80221
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1975 - October 1977.

The School Health Curriculum Project (SHCP) Demonstration Program conducted by School District No. 12 in Adams County, Colorado was designed to maintain a demonstration training and support center to incorporate the SHCP into the district's curricula. The SHCP curriculum consisted of four intensive 8- to 10-week units, one each at the fourth, fifth, sixth, and seventh grade levels. Each unit was organized around a body system and all that is related to it. Inservice training for teachers consisted of 60 hours of indepth workshop activity for teams consisting of two classroom teachers, a principal, and one or two curriculum support personnel. The program in District 12 was to include training teams in the fifth grade unit, including at least two teams from outside the district and at least one team from a school with a high percentage of native American boys; providing support to trainee districts; and taking measures to involve and gain support from groups such as State departments of health and education, legislatures, regional Native American agencies, State voluntary and professional health groups, teacher and administrator organizations, and the Department of Health, Education, and Welfare. Special attention was to be given to all aspects of the model curriculum and all strategies of the project that relate to Native American schools. The district staff was to submit quarterly progress reports, an account of plans for training and Native American and State agency involvement, and draft and final versions of a summary of all project activities.

81P-1280
School Health Curriculum Project (SHCP) Demonstration Program.
American Lung Association, 1740 Broadway, New York, NY 10019
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
May 1975 - May 1978.

The School Health Curriculum Project (SHCP) Demonstration Program was designed to develop and test new health education units for primary school students. The American Lung Association (ALA), the administering organization, was to work with the staff of at least one school district to develop the curriculum and was to submit written outlines of the prototype units for at least two grade levels. Specifically, the ALA contracted to provide staff services to work with a local school district active in SHCP; secure the services and resources of the State and local lung associations in cooperative support activity; provide technical assistance, consultation, and direct support to the local school district as it proceeds to outline the various aspects of the curriculum; develop a prototype training schedule for introducing new units to teams of educators from other districts; convene at least one national meeting for national health organizations to solicit their help in development of the units; provide information on the curriculum through routine channels of the ALA; and monitor conformance of the local school districts and community agencies to the project delivery schedule. The curriculum units were to be designed for sequential use with students in kindergarten through third grade. Project staff were required to submit a description of plans and arrangements for the project within 30 days of the initiation of the contract, quarterly progress reports, a draft report addressing the activities of the entire project after 11 months, and a final report on or before the last day of the contract.

81P-1281
School Health Curriculum Project (SHCP) Demonstration Program.
San Jose State University Foundation, San Jose, CA 95192
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
June 1974 - June 1977.

The School Health Curriculum Project (SHCP) Demonstration Program was to provide staff services and training and resources for continued development of the SHCP developed by the National Clearinghouse for Smoking and Health. The health curriculum model consisted of one intensive unit of study for each of the fourth, fifth, sixth, and seventh grade levels. Each unit concentrated on one body system and all that relates to the health of that system. The 8- to 10-week units employed a variety of classroom education techniques and resources and emphasized pupil participation and involvement of school administrators, parents, and community health personnel. The 60-hour teacher training model was to instruct two teachers, a principal, and one or two curriculum support personnel in the use of classroom resources. The health education development strategy at the district level was to involve establishment of two successful classroom examples of each unit in one school of a district, followed by staged establishment of other units. The evaluation model was to involve assessment of changes in attitudes and behavior on the part of all teacher and student participants and of the community as a whole. Specific activities to be performed by the San Jose State University Foundation, the administering organization, included sponsoring an 8-day workshop to train eight teams of at least three members each in the fourth grade unit; visiting two sites within 9 months of the workshop; revising fifth grade lung and sixth grade heart units; sponsoring an 8-day workshop to train five four-member teams of educators in the seventh grade unit; visiting two sites within 9 months of the seventh grade workshop; holding one to two meetings of at least 1.5 days for the coordinators of project training centers; and developing at least one additional prototype unit at the primary or upper junior-high grade level. Periodic reports on project schedules and activities were to be submitted throughout the project years.

SEX EDUCATION

81-1282
Misinforming Pregnant Teenagers.
Ambrose, L.
Family Planning Perspectives 10(1):51-53, 57, January-February 1978.

A review of educational materials available to pregnant teenagers indicates that few resources exist, and few of those are appropriate to the adolescent's needs. Omissions include symptoms of pregnancy, pregnancy tests, abortion, the possibility of miscarriage, employment, child care, educational counseling, medical care, and economic help. A review of 1,500 resources considered by the Office of Education and the National Institute of Education to be most helpful to those working with adolescent parents indicates the widespread reliance on nontextbook sources. Topics covered in the resources include child development, parental responsibility, the stages of infant growth, money and household management, needs of handicapped children, and parent-child relationships. A telephone survey of 33 national voluntary and professional organizations, social agencies, Federal Government offices, and corporations involved in some way with pregnancy located less than 24 resources on pregnancy and only 3 resources specifically for teenagers. 19 references.

81-1283
STD (Sexually Transmitted Disease) Fact Sheet, Edition Thirty-Four.
Bureau of State Services (DHEW, CDC), Atlanta, Ga. Venereal Disease Control Div.
Atlanta, Ga., the Division, (HEW Publication No. (CDC)79-8195), 37 p., 1979.
Available from: NTIS; Order No. HRP-0030401.

An overview focusing on the transmission of venereal diseases in the United States and on programs to eradicate the problem is presented. Gonorrhea is the most common of the reported communicable diseases in the country, while syphilis is the third most common communicable disease. Control measures encompass the support of physicians for venereal disease education in schools, hotlines, mass media campaigns, legislation, and other efforts on local, State, and national levels. Specific educational and outreach programs are being implemented for the general public, patient populations, physician extenders, native Americans, and gays. Tables and graphs depicting the variables associated with venereal disease, such as sex, age, geographic location, and population distribution are provided.

81-1284
Resistance to Sex Education: A Constituency Perspective.
Clawar, S. S.
Journal of Sex Education and Therapy 3(1):28-32, 1977.

Community opposition to sex education can perhaps be explained from a constituency perspective. A review of the literature reveals that typical parental concerns result from (1) a misunderstanding of program intentions, (2) a lack of information about the teachers' qualifications as sex educators, (3) concerns about the focus of particular teachers, (4) concerns about the moral character of the teachers, (5) concerns about the age of the teacher, (6) beliefs that the program would teach sexual techniques, (7) feelings that they will be unable to cope with the information available to their children, and (8) responses to rumors concerning content or possible negative influences of sex education. Resistance is likely to come from parents in lower socioeconomic classes and those with children not yet past puberty. Programs addressing sexual topics that relate to actual behavior are most likely to be resisted by parents. Two studies found that teachers and administrators were more likely than parents to resist sex education that involved a broad range of topics. Resistance by administrators resulted from their fear of negative parental reaction during the initiation of the program. Teachers indicate that sex education is a peripheral subject, and some think that they are inadequately trained to teach it. Students indicated resistance on the basis that their teachers were already overloaded, but indicated an interest in sex education. 9 references.

81-1285
Venereal Diseases: A Teachers' Guide.
David, V.
Des Moines, Iowa, Iowa State Department of Health, Information and Education Section, 72 p., March 1979.
Available from: ERIC; Order No. ED-179 520.

Guidelines to aid health teachers and school administrators in Iowa to implement an effective venereal disease education program are provided. Subjects addressed by the model program include the serious nature of venereal diseases as virulent infections that have reached epidemic proportions among the young, the distinct nature and effects of gonorrhea and syphilis, sexually transmitted diseases other than syphilis and gonorrhea, and the ability of current medical procedures to detect and treat venereal diseases. Discussion topic outlines include individual and community responsibility to control venereal diseases, the significance of Iowa laws relating to the prevention and control of venereal diseases, the significance of education and case detection in the control and prevention of venereal diseases, and reasons for the epidemic rise in gonorrhea infection at a time when other communicable diseases are under control. A questionnaire to evaluate students' understanding of the concepts and topics discussed and a narrative overview of the extent and effects of venereal diseases in the United States are appended.

81-1286
Sex Education for Teens Debated (Letter).
Fribourg, S.
Family Planning Perspectives 12(1):5, January-February 1980.

Though research data indicate that young adolescents have frequent sexual intercourse and that the incidence of pregnancy among young teenagers is high, clinical experiences suggest that even these findings underestimate the situation. In addition, researchers place too much emphasis on the need to educate adolescent females, neglecting to give proper emphasis to sex education for males. In the area of contraceptives, diaphragms are often categorized as a nonmedical contraceptive, yet a diaphragm can only be obtained after a fitting by a physician. In judging whether the rates of intercourse and pregnancy are higher than researchers report, it must be remembered that the sporadic nature of early sexual experiences can contribute to high incidence of pregnancy. The positive correlation of ages of menarche and of first intercourse explains, in part, the high level of fecundity among teenagers who begin having intercourse at a relatively early age.

81-1287
Sources of Information and Materials Relating to Human Sexuality.
Indiana Univ., Bloomington. Inst. for Sex Research.
Bloomington, Ind., the Institute, 11 p., January 1979.

Sources of information and materials relating to human sexuality are presented for use by researchers, educators, medical personnel, counselors, and other people working in the field of human sexuality. Sources listed include periodicals, newsletters, organizations, audiovisual materials, dictionaries, directories, bibliographies, catalogs, general reference tools, textbooks, and materials addressing special topics such as professional training and venereal disease.

81-1288
Counseling Sexually Active Very Young Adolescent Girls.
Peach, E. H.
MCN; American Journal of Maternal Child Nursing 5(3):191-195, May-June 1980.

Sexually active 10- to 14-year-old girls are generally referred to community health clinics in Nampa, Idaho, by a social worker, parent, older friend, or school nurse. Girls involved with boys in unsupervised boy-girl activities may be questioned directly about sexual activities. Vague physical complaints together with repeated visits are warning signs that sexual activity may be one of the girl's problems. Homeless girls are particularly prone to sexual activity at an early age. Sexual abuse or incest should be considered when girls continually re-enter the clinic for urinary tract infections or vaginal discharges. An important consideration in seeking and providing information about sexuality and sexual activity is to know the individual State laws concerning the right of minors to receive contraceptives or treatment for venereal disease without parental consent. Nurses and counselors should use a warm, honest, concerned interviewing style and have a sense of humor. The extent of the adolescent's knowledge of menstruation, conception, pregnancy, and contraception should be determined. Individual interviews, rather than group discussions, appear to be the optimal counseling format for this age group. Helping the adolescent girl to discuss her experience and directing sexually active adolescents toward the use of oral contraceptives seems the best possible approach. 6 references.

81-1289
Education in Family Planning: What Route to Take? What Difference Does It Make?
Sikes, O. J.
International Journal of Health Education (Geneva) 22(4):206-210, 1979.

Though the degree to which members of the helping professions impose their views on their target audiences has received little research attention, family planning communicators have received repeated criticism for this activity. In spite of this, international family planning programs have recently been initiated by the Food and Agriculture Organization, the International Labor Organization, the United Nations Fund for Population Activities, and the World Health Organization. Mass media efforts in the area of family planning have been implemented by the Press Foundation of Asia; the Arab Center for Information Studies on Population, Development, and Reconstruction; the Latin American Development Journalists Association; and others. To ensure that such programs are acceptable to the mores of the target audiences, planners must include program mechanisms that allow feedback from the community while providing information to enable the audience to make reasoned decisions. Overall, planners and communicators must help each individual weigh the benefits and costs of family planning, control influences external to decision making (clinic environment, accessibility of services, and acceptability of methods) to enhance acceptability of family planning, and provide a strong base for family planning at the community level. 7 references.

81P-1290
Speak-Easy.
Temple, H.
University of Rhode Island, University Health Services, Health Education Department, Roosevelt Hall and Potter Building, Kingston, RI 02881
Funding Source: Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
September 1973 - Continuing.

The Speak-Easy program at the University of Rhode Island was designed to provide sexuality information, peer counseling, and referral services for students with sex-related problems. The program provides a hotline, a drop-in center, workshops, birth control education classes for the university women's clinic, and information booths in the student union building. A resource library is also available, and Speak-Easy programs are advertised on the campus radio station. Approximately 2,000 students are served annually. The program is staffed by a health educator, a clerk, and 40 trained student volunteers. Records are kept on student participation in the program.

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CURRENT AWARENESS IN HEALTH EDUCATION

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COMMUNITY HEALTH EDUCATION

81-1291
Health Education Needs of Urban Minorities (Grupos Etnicos Minoritarios e Indigenos).
Ashley, M.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 9 p., (1981).
(Spanish and English)
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Significant problems indicated by high mortality and morbidity rates among blacks, Chicanos, Puerto Ricans, native Americans, and Asians living in the urban ghettos of North America suggest the need for integration of social and economic components in health education efforts aimed at these populations. Crowded living conditions, beliefs and customs that conflict with national norms, language barriers, high rates of unemployment, and ignorance of existing health delivery systems have combined to alienate urban minorities. Minority members see physicians less often and wait longer for services than whites do. To respond to these problems, health education resources must focus on support and advocacy services for health care resources, mediation of tension due to incongruent cultural values, promotion of efficient use of existing resources, demystification of the health care system, and motivation for assumption of personal responsibility concerning health care. Health education and community organization principles must become integral parts of program planning. Finally, the findings of learning theorists, marketing specialists, and behavioral scientists must be used in developing and implementing educational materials. 10 references.

81-1292
Urban Environment, Housing and Safety: The Health Education Response and Role.
Barnes, S.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 6 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Survey data from a study conducted by West Indian sanitary engineers reveal health problems related to sanitation, housing, and safety in urban areas of the Caribbean. Such problems require educational interventions at the community level. Wasted fresh water, untreated disposal of waste water and solid wastes, disposal of refuse by shantytown residents in streams or vacant lots, disposal of industrial wastes into streams or the sea, congested living conditions in squatter villages, contaminated food, high accident rates, and related problems have resulted from overcrowding in urban areas. A comprehensive community sanitation and renovation program was initiated in one country in the Caribbean in response to a thorough diagnostic report on the country's conditions by a health educator. Thus, it appears that the more than 60 health educators in the Caribbean can have some impact. Health educators who wish to be effective in improving sanitation in their communities must establish close ties with governmental and nongovernmental community interests, demonstrate means of unlocking potential political resources, attack economic problems at the base of health problems, devise methods of mobilizing urban communities behind specific problems, promote school health education programs, and promote training programs in health-related areas for national and community leaders.

81-1293
Programa Educativo en Nutricion: Algunas Sugerencias (An Educational Program in Nutrition: Some Suggestions).
Bartha Vargas, L.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Provider-Policymaker Setting, 15 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Some suggestions on a nutrition education program are presented from a Latin American viewpoint. Educational programs should be directed toward mothers and physicians by means of television, radio, and publications. Some factors which interfere with program success include governmental politics, media propaganda, myths, and popular traditions. To avoid interference and obstacles, three alternatives should be considered: audience participation, program integration and coordination, and topic content and presentation. Planners of a good nutrition program should integrate and coordinate its efforts

with other programs, sidestep obstacles and interference, consider the audience, and use alternative means to reinforce health messages.

81-1294
Parent Resource Directory: A Twin Cities Area Guide to Educational and Social Programs for Parents of Preschoolers.
Childbirth Education Association of Greater Minneapolis-St. Paul, Minn.
Minneapolis - St. Paul, Minn., the Association., 180 p., May 1978.

A resource directory to educational and social programs available in Minneapolis and St. Paul is provided for parents of preschool children in the Twin City metropolitan area. Arranged by geographical location, each listing gives the names of director and contact person, a brief program description, a checklist of services provided and types of participants served, fees, and other pertinent information regarding time and place.

81-1295
Community Cardiopulmonary Resuscitation.
Cobb, L. A.; Hallstrom, A. P.; Thompson, R. G.; Mandel, L. P.; and Capass, M. K.
Annual Review of Medicine 31:453-462, 1980.

In the fall of 1971, the Seattle Fire Department initiated a community cardiopulmonary resuscitation (CPR) program that offered CPR training to 100,000 residents, about 20 percent of the city's population. The course, which is promoted through the news media and several service organizations, is presented by trained paramedics in a 45-minute lecture-demonstration. Topics include cardiac arrest and appropriate diagnostic measures, the principles and techniques of CPR, the symptoms of heart attack, and whom to call for assistance. Through August 1979, 223,000 students had been trained. Analysis of questionnaires administered to 1,700 randomly selected students indicated that they were generally young, well-educated white-collar workers. Immediately after training, 151 randomly selected students were tested on a recording manikin. Over 70 percent of the students performed satisfactorily. Forty-three students were tested immediately after and 6 months after the course; only three students showed a significant decline in performance. Skill testing of students 6 and 12 months after completion of the course indicated the need for use of short, simple refresher devices such as illustrations, televised instructions, or manikin practice. 23 references.

81-1296
Centro de Educacion en Salud del Mango: Innovacion Para Promocion de la Salud en una Comunidad Rural de Puerto Rico (The Health Education Center in Mango: Innovation for Health Promotion in a Puerto Rican Rural Community).
Cruz de Seneriz, S.; Lebron de Aviles, C.; and Rodriguez de Leon, I. S.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 35 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5KO.

A family health program in rural Puerto Rico trains physicians to treat family health problems. Program strategies include establishing a health education center, identifying and training community leaders, organizing committees, and identifying community needs. The program offers educational activities on bilharzia, tuberculosis, tetanus, diphtheria, cardiopulmonary resuscitation, oral health, environmental health, and pulmonary health. The program has proven successful as evidenced by the community's acceptance of the health team and by its adoption of lifestyle changes. In the future, the program will attempt to expand the center, continue to incorporate different disciplines, establish a library, train youths and adults to assume teaching, continue innovative projects, and expand to other rural communities. Data tables and maps of the community are presented.

81-1297
Health Education: Where Are You?
Englefield, R. M.
New Zealand Nursing Journal (Wellington) 73(2):36, 38, February 1980.

Thirty-three nursing students at Nelson Polytechnic Institute in New Zealand polled 165 persons using a simple 5-question instrument to investigate the public's use of iodized salt. The students approached persons 18 to 80 years old in their homes and in stores and supermarkets. The majority of the respondents were 20- to 35- year-old women. Approximately 23 percent of the women were from families which did not use iodized salt; many did not understand the importance of its use. Results suggest the need for more education on the benefits of using iodized salt in order to prevent goiter. Making iodized salt cheaper than normal salt would help reinforce any educational effort.

81-1298
A Hundred Years of Dental Health Education.
Fox, B. and Maddick, I.
British Dental Journal (London) 149(1):28-32, July 1980.

The origins of dental health education in Great Britain are obscure and probably developed from the advice which practitioners gave to their patients as a part of their treatment. In 1768, a book on diseases and deformities of the gums was published that gave advice to parents and governesses about the dental care of young children. Individual practitioners continued this tradition, and some produced material for their own patients. The Dentists Act of 1878 made dentists responsible for public health education. During the 1890's, numerous surveys of the British public resulted in several reports of the extremely poor condition of the dental health of the populace. As a result, dentists recommended fibrous diets to replace diets relying mostly on soft foods, white flour, and white sugar. Efforts in the late 19th century to improve the oral health of the military concentrated on training rather than education. Early in this century, the School Dentists' Society instituted a program to provide toothbrushes to schoolchildren and military men. As the century progressed, the Ivory Castle League, the Dental Board of the United Kingdom, the Dental Health Committee of the British Dental Association, and others sponsored a number of public education campaigns. Recently, commercial and public health education programs, which had had strained relations for years, began combining their efforts for public education. Numerous references.

81-1299
A Statewide Approach to Diethylstilbestrol--The New York Program.
Glebatis, D. M. and Janerich, D. T.
New England Journal of Medicine 304(1):47-50. January 1, 1981.

In August 1978, the New York State Legislature passed a bill to develop a program that would deal with health problems associated with exposure to diethylstilbestrol (DES). The New York State Department of Health's Bureau of Cancer Control, which administered the program, designed public awareness interventions and implemented a telephone survey of 1,000 randomly selected women 15 to 75 years old. Only 40 percent of the women had heard of DES, and 75 percent of those who were familiar with DES were misinformed about the years when DES had been used, why it had been used, and what health problems are associated with exposure. Of the 346 women who knew about DES and who were pregnant between 1941 and 1971, 8 had taken DES during pregnancy. Based on these figures, it can be estimated that 120,000 New York residents had been exposed to DES in utero and 140,000 mothers had received DES during pregnancy. The program consisted of a statewide, bilingual multimedia campaign. Contacts were made with all county health departments, the New York State Medical Society, all involved practitioners, 150 public health organizations, family planning centers, 300 hospitals, commissioners of 60 municipal social service agencies, and numerous cooperative extension groups and community leaders. Seven screening sites were established, and a DES registry was instituted. The program cost for the first full year of operation was approximately 1 dollar per exposed resident. 21 references.

81-1300
Successful Planning and Implementation of a Hospital-Based Community Self-Help Group for Patient and Community Cardiac Education.
Hughes, D. T.
Hospital Topics 58(2):25-27, March-April 1980.

To facilitate effective rehabilitation from heart disease, to increase awareness of measures to prevent further damage, and to acquaint former patients and their families with current concepts about health and illness, a community cardiac education program was established at Thomas Jefferson University Hospital in Philadelphia. The philosophy behind the program is that it is the responsibility of a hospital to provide preventive health care information to the community, just as the hospital is responsible to provide care once a patient is admitted. Periodic followup interviews of former patients determined that they lacked both knowledge and understanding of heart disease process and aspects of preventive care. Goals of the hospital-based community education program are to (1) provide the public with information on cardiac disease; (2) correct misconceptions of heart disease; (3) educate the spouse and family on heart disease; (4) provide the public with appropriate literature for reference and access to resource persons; and (5) provide an environment in which people can share their experiences of cardiac disease. Two nurse program coordinators lead the weekly sessions with a former patient and the patient's spouse serving as group leaders. A variety of guest speakers, film strips, and free literature are featured and group discussion is encouraged. Among the topics covered are signs and symptoms of a heart attack, risk factors of cardiac disease, proper dietary management, and cardiopulmonary resuscitation. Data show that offering a community cardiac education program increases public awareness of the disease, high risk factors, and therapeutic regimens. Effective teaching programs may also lead to decreased hospital

admissions and shorter stays. Future plans for community education programs include diabetes mellitus, hypertension and stroke, and other aspects of preventive health care.

81-1301
Educacion en Salud Para la Salud Familiar y Planificacion Familiar en el Sector Urbano (Family Health Education and Family Planning in Urban Areas).
Ibarra Fernandez, N.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 6 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Urbanization is characterized by an increase in the population and by migration from rural to urban areas. Such an increase in population in urban areas causes health problems, because the migrants construct crowded, rudimentary housing with poor sanitation. These conditions have an enormous impact on the health of the family and the community. An effective health education and family planning program stimulates the active participation of the community in the identification and solution of problems. Health education is a necessary part of programs which strive to improve the quality of family and community life.

81-1302
Activating the Consumer About Pregnancy and Childbirth.
James, G. B.
Health Education 11(6):19-21, November-December 1980.

Pregnancy and childbirth are areas in which there is increasing emphasis on development of self-care skills and an "activated" consumer approach to maximize efficient use of the health care system. Health educators in secondary schools and colleges are in a position to provide students with primary prevention and health promotion activities about human reproduction. Several prepregnancy health education programs have been developed. Several States now have projects to decrease maternal and fetal mortality while increasing the health and welfare of the mother and child. Health educators need to be aware of the many consumer issues involved in education about pregnancy, childbirth, and aspects of the short- and long-term health of the child related to the mother's behavior and choices during pregnancy. Included are lists of selected consumer books on pregnancy and childbirth; consumer-oriented groups concerned with pregnancy and childbirth; controversial issues related to obstetrics; and alternative childbirth methods. Health education in the areas of pregnancy and childbirth should make consumers aware of the benefits and risks of various childbirth methods and help to minimize incorrect use of obstetrical practices. 8 references.

81-1303
Grupos Etnicos Minoritarios (Ethnic Minority Groups).
Jimenez Velasco, V.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Provider-Policymaker Setting, 17 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

The goal to improve the health of ethnic minority groups, as outlined by the World Health Organization, emphasizes the sociocultural environment of such groups. The health needs and demands of the indigenous can be defined by analyzing demographic patterns and mortality and morbidity rates. The indigenous populations are characterized by poor health and high mortality and morbidity rates, particularly from infectious diseases. In some areas, medical attention is nonexistent. Social, economic, and political factors must be considered when establishing a health education program in these areas. Data tables on mortality, population, and morbidity are included.

81-1304
Educacion Para la Salud en las Americas: Promoviendo Salud Para Todos a Traves de Participacion de la Comunidad. "Necesidades y Demandas de Educacion Para la Salud en los Trabajadores Migrantes del Medio Urbano" (Health Education in the Americas: Total Health Promotion Through Community Participation. "The Needs and Demands of Health Education for Rural Workers Who Have Migrated to Urban Areas").
Lozano Jimenes, J. L.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 5 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5KO.

The need for health education in urban areas is linked to the migration of workers from rural areas. Health education focuses on the individual who lacks adequate knowledge to maintain good health and on the individual who has the knowledge but does not practice good hygiene for various reasons. Besides general health knowledge, problems such as drug addiction, alcoholism, psychosocial tension, and industrial accidents must be approached. Duplicity in the integration and coordination of different sectors of the community involved with health education is a common occurrence and should be avoided. Community members who can be trained to participate in the health team effort will facilitate the promotion of health and safety behavior.

81-1305
Presentation to International Union for Health Education.
Michaels, L. G.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 9 p., June 2, 1981.
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Pittsburgh's Health Education Center, which serves a 10-county urban area with a population of over 3 million, is part of a growing movement that emphasizes education for self-care. Each year a professional staff of health educators, working in cooperation with other agencies, provides classes, consultation, and training for over 2,000 health professionals; makes health education library resources available for health professionals; and serves as national consultants to universities, industries, and government agencies. A community panel studied surveys and analyzed several other programs before making recommendations that have become central to center planning. Successful implementation of health education programming involves the cooperation of the health services provider, media, the educational sector, consumer groups, religious and civic groups, business, labor, industry, voluntary health agencies, and government agencies. An effective holistic approach will provide holistic mental health education, encourage community involvement, and provide opportunities to acquire self-care skills. 22 references.

81-1306
Substance Abuse in Rural Areas.
Newman, I. M.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 10 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

An overview of the drug abuse problem in rural areas of the United States and of rural characteristics that restrict abusive behavior provides health educators with background for program development in rural areas. Drug abuse survey data suggest that rural residents are less prone to drug abuse than urban residents and that the subcultures that develop around adolescent drug use differ in composition and character across the two settings. Characteristics of rural areas that contribute to low levels of drug abuse include tightly integrated social networks, close extended family ties, the "close-knit" nature of rural schools that constitute the principal socializing agent for rural children, clearly visible leadership, simple patterns of communication, homogeneous value structures, and overall community stability. Factors working against effective drug control programs include low population densities that demand extensive travel for adequate outreach, suspicion of outsiders, lack of health workers familiar with rural conditions, and slowness in adopting new behavior patterns. 7 references.

81-1307
Defining the Need: An Analysis of Varying Teaching Goals in Antenatal Classes.
Perkins, E. R.
International Journal of Nursing Studies (Oxford) 16(3):275-282, 1979.

Surveys of group teaching by health visitors and instructors of antenatal classes in hospitals were carried out in 1977 in an industrial area of England to analyze the varying teaching goals in antenatal classes. Classes were arranged in five of the seven maternity units in the area and in numerous centers in the community. All maternity units and 120 of the 165 health visitors returned the survey questionnaire. A total of 92 health visitors taught classes. The emphasis given in various syllabi to different topics was analyzed by assigning values based on the total respondents who included the topic and calculating the mean for each topic. Topics perceived as important by most instructors included labor, pain relief, films of births, breast-feeding, artificial feeding, and skills such as bathing the baby. Most of the courses were for women only, and course descriptions revealed ambivalence over the male role in birth and child care. Many of the courses provided little or no preparation for hospital confinement, and topics associated with diet or immunization received little emphasis. It would seem that an optimal approach would address self-care in pregnancy, knowledge to reduce anx-

iety, skills to handle pain in labor with a minimum of technical assistance, parenting skills, and emotional support. 15 references.

81-1308
Education Activities in a Community Mental Health Center--How It Should Be Developed and the Services That It Comprehends (Actividades de Educacion en un Centro de Salud Mental y Como Deben Ser las Mismas y los Servicios que las Comprenden).
Santiago, M.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Provider-Policymaker Setting, 6 p., (1981).
(Spanish and English).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Educational activities of a community mental health center should aim at primary high-risk groups in the communities served. A complete intervention strategy, involving all facets of intervention from needs assessment through intervention and evaluation, must be established for each group. The basic functions of a center in effecting these interventions include provision of education, coordination with community agencies, provision of consultation services, and development of community resources. Small discussion groups involving representatives of the target audience are essential during planning and programming implementation phases. Typical high-risk groups include divorcees, unmarried mothers, geriatric patients, unemployed persons, children and adolescents, and those with problem neighbors. For a typical community of 100,000 to 150,000 persons, the staff of a center should include 3 mental health educators with master's degrees, 9 health educators with bachelor's degrees, a psychiatrist, a psychologist, and an occupational therapist.

81-1309
Preventive Medicine: The Library Prescription.
Schell, C.
Library Journal 105(8):929-931, April 15, 1980.

An overview of the policies and practices of medical libraries in providing reference services to the public and a survey of the largest medical libraries in each State point to the need for establishing standards in the delivery of health and medical information to the public. An earlier survey showed that although 82 percent of the publicly funded medical school libraries are open to the public, only 32 percent of them offer public services beyond access. The present movement of general practice away from specialized medicine may prompt parallel changes in libraries to meet the needs of family physicians and their patients. Of the 51 medical libraries receiving questionnaires in the recent survey, 37 returned the completed forms. Data indicate that 91 percent are open to the public, 65 percent provide limited service to the public, and 20 percent provide full services to the public. Approximately 43 percent of the libraries refer most questions from the public back to a public library. These findings suggest a need for more cooperation among libraries and for a more efficient consumer health and medical information system for the information seeker. 9 references.

81-1310
Nutrition Education in the Urban Area.
Seijo de Zayas, E.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 7 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

The importance of nutrition to the immediate health status and long-term development of the individual underlies nutrition education efforts. This is particularly true for urban areas, in which the complexity of life results in poor nutrition. Working mothers, housing problems, commuting patterns, unregulated health food enterprises, and related problems have resulted in poor nutritional behavior even among the wealthy. Lack of continuity in nutrition education programs constitutes one of the major drawbacks associated with efforts to improve nutritional behavior in urban areas. Government food distribution programs should be accompanied by nutrition education programs to ensure efficient use of the food or food stamps. In urban areas, mass media could be particularly effective in altering the nutritional behavior of the audiences. Finally, regardless of the means of delivering nutrition education to the public, the community should be involved in all stages of program planning and implementation.

81P-1311
Change Your Mind About Your Body.
Pickford, W.
Blue Cross and Blue Shield of Rhode Island, 444 Westminster Mall, Providence, RI 02901
August 1976 - Continuing.

The "Change Your Mind About Your Body" program is designed to promote healthy lifestyles for more than 800,000 Blue Cross and Blue Shield subscribers of Rhode Island. The program emphasizes self-recognition and personal responsibility for monitoring stress, nutrition, alcohol and drug use, cancer risk, and minor illnesses. Services offered include booklets, posters, leaflets, speakers, films, and other materials supplied to company groups and the general public through Blue Cross and Blue Shield publications, billboard advertising, and television and radio spots. In addition to imparting health information, the program offers the names, addresses, and telephone numbers of the local community council referral services and of the YMCA's cardiovascular fitness course. The YMCA physical fitness program recommends a physician's examination prior to the stress testing given under medical supervision and provides an individual exercise prescription based on the test results. Smoking cessation clinics can be arranged on a company site with presentations from members of the medical profession and in-house group discussion leaders. Health screening facilities are provided by the Division of Occupational Health (Rhode Island Department of Health) and the Rhode Island Cancer Society's Public Education Committee. Diet counseling is provided by the Rhode Island Department of Health nutrition services and the Rhode Island Heart Association. No formal evaluation has been done for this program; however controlled studies have shown that similar programs have been successful.

81P-1312
Mercy's Center for Healthful Living.
Pietrusiak, R.
Mercy Center for Health Care Services, 1325 North Highland Avenue, Aurora, IL 60506
1980 - Continuing.

The Mercy Center for Health Care Services offers education programs in the hospital community on women's issues, weight control, alcoholism, parenting, arthritis, adolescent issues, children's health, medication, cardiopulmonary resuscitation, Medicare, aging, stress management, and substance abuse. The Women's Room, the community education component, promotes open dialog among women by addressing issues that relate to normal female development. The program encourages growth and mental health and works toward prevention of emotional and psychological problems by providing a place for women to share freely with other women in an atmosphere of acceptance, confidentiality, and caring. The weight awareness group invites active participation and self-exploration by promoting an awareness of eating patterns, interpersonal interaction styles, obesity, emotional expression, and ways of increasing and maintaining self-esteem. A program designed to ease the fear children have on their first hospital visit utilizes wood miniatures of hospital equipment and dolls which resemble a family, the doctor, and a nurse. Volunteers coach potential pediatric patients on hospital procedures and answer questions. The Adolescent Unit provides an environment for self-discovery enabling adolescents to change their behavior from patterns that were nonproductive and self-destructive into satisfying and nonthreatening patterns. The adolescent behavioral modification program includes participation in school, occupational therapy, group therapy, activity therapy, and individual and family therapy.

81P-1313
NAB (Non-Alcoholic Beverage) Program
Phillips, L. A. and Whitworth J.
Kansas State Department of Social and Rehabilitation Services, Alcohol and Drug Abuse Services, 2700 West 6th Street, Topeka, KS 66606
1980 - Continuing.

Nonalcoholic beverages are promoted in a campaign by the Alcohol and Drug Abuse Services of the Kansas State Department of Social and Rehabilitation Services to encourage responsible drinking. The agency sponsors radio public service announcements and newspaper articles and brochures with nonalcoholic beverage recipes. The Non-Alcoholic Beverage Program (NAB) brochures have been distributed by officers of the Kansas Highway Patrol in high schools. A governor's conference offered a NAB bar, and a local restaurant owner put 10 nonalcoholic cocktails on the menu. The University of Kansas Alcohol Abuse Prevention Program focuses on the special needs and emotions of students by offering information programs in residence halls, fraternities, and sororities. NAB materials are available in grocery stores. NAB personnel have hosted nonalcoholic beverage parties at various conferences throughout the State. One effective effort was a meeting of the Alcohol and Drug Abuse Services' Citizens Advisory Committee, with members of the press in attendance, at a bar in Manhattan, Kansas, that serves nonalcoholic beverages.

81P-1314
North Shore Institute of Health Information and Education Services.
Frosh, W. J.
Union Hospital, North Shore Institute of Health, 500 Lynnfield Street, Lynn, MA 01904
1974 - Continuing.

Union Hospital's North Shore Institute of Health in Lynn, Massachusetts, offers health maintenance and promotion programs for schools, the community, businesses, and industry. Services offered include smoking cessation, stress management, alcohol awareness, fitness and exercise courses, nutrition and weight control, and cardiopulmonary resuscitation (CPR) and choke-saving techniques. All programs are conducted by qualified medical and technical personnel who use professionally accepted equipment, techniques, and information. The smoking cessation program offers six sessions in 3 weeks and a followup program designed to provide a supportive environment in which the participants are given an opportunity to examine their lifestyle choices. The stress management program promotes stress reduction and individual development of coping skills. The alcohol awareness program identifies and manages the problem by assisting the affected employees in recovery in addition to providing alcohol abuse information. The fitness and exercise course offers three 4-hour sessions and encourages practice for at least 5 hours a week. Program staff monitor the effects of the exercise program. The nutrition education and weight control program provides individual assessment, diet planning, a supportive exercise program, and assistance toward permanent change in unhealthy eating patterns. Specific needs of the individual participants are examined by a qualified nutritionist. Qualified instructors in the CPR and choke-saving program train participants to recognize early signs of cardiac and respiratory failure and indications of choking. Participants learn to respond with the appropriate lifesaving technique. Other services include health magazines, a resource library, informational brochures, a telephone information service, radio messages, and individual nutrition counseling.

81P-1315
Patient Activated Care for the Rural Elderly.
Cohen, S. and Gaarder, L. R.
Mountain States Health Corporation, P.O. Box 6756, 1303 W. Fort Street, Boise, ID 83707
Funding Source: Northwest Area Foundation, St. Paul, Minn.
May 1980 - May 1982.

The Mountain States Health Corporation of Boise, Idaho, a nonprofit, public organization, has received a grant from the Northwest Area Foundation of St. Paul, Minnesota, to introduce self-care programs for elderly persons in rural Idaho, Montana, Washington, and Oregon. The programs consist of classroom activities designed to improve health knowledge and skills and which are tailored to the needs of each community. A local health professional or a number of professionals are selected to provide training for the programs, and a senior citizen is recruited to serve as a community coordinator. A local advisory group of senior citizens and health care professionals is responsible for identifying local needs and resources, providing advice and assistance to trainers and coordinators, and ensuring the continuity of self-care in the community. The Mountain States Corporation provides training materials, orientation, consultation, and assessment. Existing self-care curricula are adapted for use in programming. Basic topics that are covered in the typical 10 to 12 weekly sessions include self-responsibility and the medical care system, home physical examinations, treatment of common illnesses, health maintenance and chronic illnesses, mental health, injuries and other emergencies, medications, oral hygiene, nutrition, and use of alcohol and other drugs.

81P-1316
Prevention Center of the North Shore Council on Alcoholism.
Berger, S.
North Shore Council on Alcoholism, Inc., 183 Newbury Street, Danvers, MA 01923
Funding Source: Massachusetts State Div. of Alcoholism, Boston; United Way of Massachusetts Bay, Boston; United Fund of the North Shore, Beverly, Mass.
January 1979 - Continuing.

The Prevention Center of the North Shore Council on Alcoholism, in Danvers, Massachusetts, promotes community awareness of alcohol abuse. Books, pamphlets, films, and resource materials on alcohol and alcoholism are available in the center library. Consultation and resources are also available for groups, organizations, and agencies to develop, sustain, and support other alcohol education programs. Public awareness is promoted through newspaper, radio, and television by providing facts, information, and authorized opinions to dispel drinking myths. Consultation and assistance for individuals and groups facilitate change through families, schools, business, religions, health, government, and legal institutions. During holidays and other special community events, public education campaigns promote sobriety. Coordination with North Shore Region human service agencies, community groups, and local government encourages total community participation. An informal evaluation of all training and education programs and a formal evaluation of the impact of specialized campaigns are proposed.

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81P-1317
Preventive Medicine Center of Ann Arbor.
Faust, H. S. and Thar, W. E. 2220 S. Huron Parkway, Ann Arbor, MI 48104
1981 - Continuing.

The Preventive Medicine Center of Ann Arbor, Michigan, a private medical clinic, provides preventive health services to individuals and small groups in a program serving the health promotion and research needs of private business; health-care related industries; and municipal, county, and State governments. Nine preventive health programs are offered by the center: (1) the Client-Oriented Prevention Evaluation (COPE), consisting of comprehensive health-risk appraisal primarily offered to business executives and based on medical and family histories, accident and toxic substance exposure, stress, dietary analysis, physical examination and other health determinants; (2) the Cancer Prevention Program offering family history risk analysis, detection of exposure to known carcinogens, and a complete physical examination; (3) the Heart Attack Prevention Program assessing causes of heart disease with a complete medical history that covers the cardiovascular system, dietary analysis, rest and stress electrocardiogram, exercise capacity, body fat, blood count, plasma glucose, and blood lipid studies; (4) the Nutrition Assessment Program identifying physiological or psychological problems related to diet by studying family and medical histories, food intake, hair composition, body fat, blood, and urine; (5) the Exercise Prescription Program appraising the cardiovascular system's functional capacity, body flexibility, and present fitness; (6) the Family Planning Services providing information on venereal disease, human sexuality, birth control, and other aspects of reproductive health; (7) the Pre-Pregnancy Counseling Program helping families create the optimal health environment for a pregnancy; (8) the Medical Self-Care Program offering the individual the necessary skills, information, and equipment to make basic medical decisions and treat common medical problems; (9) the Medical Consulting Program providing medical consultation for individuals who want to discuss special problems. All programs insure that patients understand the causes of their problems, the methods used in diagnoses, and the most promising treatments.

81P-1318
Project COPE Community Services.
Orlando, D.
Project COPE, 117 North Common Street, Lynn, MA 01902
Funding Source: Massachusetts State Div. of Alcoholism, Boston; North Shore Council on Alcoholism, Danvers, Mass. Prevention Center.
1970 - Continuing.

The Division of Community Services, a component of Project COPE, has developed alcohol and drug abuse prevention programs that promote positive health attitudes, provide information, and encourage self-esteem among Lynn, Massachusetts, residents. The community services include the Alcohol Prevention Experience (A-PEX), the Youth Advisory Board, a grant from the State Division of Alcoholism to develop curricula and train teachers for alcohol and drug education, an internship program at area colleges, and Project STAND. APEX brings alcohol information, support, and skill development to networks of professionals, paraprofessionals, and youth groups. Activities include peer counseling instruction, an alcohol workshop, and the continuation of two youth advisory boards that sponsor youth activities. The Youth Advisory Board helps develop educational programs, sponsors alternative activities, and serves as a liaison between local youth and Project COPE. The State Division of Alcoholism grant enables Project COPE to develop curricula on alcohol and drug use, to provide information on alcohol and drugs to the community, and to train professionals and paraprofessionals to work with youth. The internship program places college students in a community-based alcohol and drug educational program that provides outreach services to community residents. Each intern is trained in substance abuse issues and community skills. Project STAND offers information, a referral center, self-help, and support groups for women with alcohol problems, women in life transition, women alone, battered women, and single parents.

81P-1319
Project GOh (Golden-Age Outreach for Health).
Ziegler, H. D. and Ward, A. L.
Fairfax Foundation, Inc., Fairfax Foundation Human Services Center, 10,000 Cedar Avenue, Cleveland, OH 44106
Funding Source: Cleveland Foundation, Ohio; Ohio Commission on Aging, Columbus.
1979 - Continuing.

Project GOh (Golden-Age Outreach for Health) is a Fairfax Foundation pilot neighborhood health network self-help program designed to encourage more family and community involvement with persons 60 years old and older in Fairfax, Ohio. Services provided to the elderly include friendship and moral support, referral to community agencies, assistance with medication and hygiene, temporary help with housekeeping, social activities, assistance with shopping, and guidance concerning nutrition and physical fitness. The 3-year program will involve training of street health workers assigned to a specific street, expanding the training of geriatric outreach work-

ers, and setting up community network to aid the elderly. A specific curriculum for street workers and outreach workers will be developed and taught to area professionals and volunteers. The curriculum will cover the basic psychology of aging, the normal process of aging, common disorders of the elderly, orientation to community resources, crisis intervention for the elderly, reality orientation, assessment of the condition of elderly clients, cardiopulmonary resuscitation, and nursing care procedures. A geriatric outreach handbook is being developed for use by workers. Street health workers will receive a self-help course as part of the curriculum. The program will be staffed by a program coordinator, a team of trained street workers, volunteers, geriatric outreach workers, and professionally trained staff. The U.S. General Accounting Office, the Ohio Commission on Aging, and several local organizations sponsor the program. Pre- and postprogram tests and assessment of trainees' ability to deal with the elderly by an advisory board of participating community agencies will provide evaluation of the program.

81P-1320
Tom Shipp Alcoholism Treatment System (TSATS).
Bennett, B.
Community Council of Greater Dallas, 1900 Pacific Building, Suite 1725, Dallas, TX 75201
Funding Source: National Inst. on Alcohol Abuse and Alcoholism (DHHS, ADAMHA), Rockville, Md.
1975 - Continuing.

The Tom Shipp Alcoholism Treatment System (TSATS) provides the black community in Dallas, Texas, with community outreach and awareness services. During its 5 years of operation, TSATS has funded three outreach efforts in the black community. Initially, a detoxification service, TSATS developed a community organization strategy that gave rise to a community task force on alcoholism. During its first year of funding, the task force implemented a 24-hour hotline that was staffed by 15 volunteers; community education activities that included community conferences, small group meetings, and a public relations campaign; and advocacy activities that included visits to agencies, inservice training sessions, and task force conferences for agency personnel. The hotline was used for crisis intervention, provision of information on psychological and physiological effects of alcoholism, and referral. Transportation was provided for those in a crisis situation. Three community education programs were implemented to increase awareness of alcoholism as a disease, provide information on local community resources, and encourage participation in self-help groups. The public relations campaign coincided with the implementation of the hotline and the first community conference. Posters, wallet-sized cards, and pencils were issued to advertise the hotline, and a local television station presented a 30-minute program on alcoholism. Referrals are made to a number of agencies within the community. Task force activities have been evaluated from hotline calls and feedback from community education program participants. The hotline receives 15 to 30 calls per month.

81P-1321
Wiconi Community Education Project.
Erickson, G.
South Dakota United Indian Association, 919 Main Street, Suite 101, Rapid City, SD 57701
Funding Source: Dept. of Health and Human Services, Washington, D.C.
October 1, 1980 - Continuing.

The Wiconi Community Education Project, under the auspices of the South Dakota United Indian Association and the South Dakota Department of Health, was designed to (1) educate Native Americans on the consequences of teenage pregnancy, (2) promote a better understanding and acceptance of comprehensive health education, and (3) explore strategies for implementing cooperative community health programs that reduce teenage pregnancy and improve participants' general health and well-being. Community-based workshops are offered as a forum for parents and service providers to explore common problems, to help preteens and teenagers develop a positive self-image and acquire reproductive information, and to help nurses identify gaps in training and education that hinder health promotion for the target population. Workshop topics include anatomy and physiology, family planning methods, fertility awareness, venereal disease control, values clarification, peer pressure recognition, peer counseling and coping skills. A speakers' bureau is available on local, State, and regional levels. At the end of each workshop, participants complete an evaluation form. Evaluation results have indicated that participants are satisfied with the workshop content, the quality of the instructors, and the overall coordination of the workshops.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-1322
An Incentive-Based Employee Fitness Program.
Brown, J.
Health Education 12(2):23-24, March-April 1981.

Davidson Louisiana, a building products distributor with offices in eight Louisiana cities, conducts a unique employee fitness program in which employees are rewarded with vacation credit. The fitness program is the fourth component of an incentive program based on total sales, distribution of sales, and attendance at sales meetings. The program is introduced each year in January via a personnel meeting and distribution of an explanatory booklet. Participants are screened, and walking, jogging, swimming, exercise, tennis, racquetball, handball, basketball, golf, softball, cycling, skiing, or weight-lifting programs are outlined for each participant. Each participant must exercise at least three times per week. Goals are established for body weight and blood pressure, and these indices are monitored at 5-week intervals at regional offices. Points are offered for maintaining self-reported exercise schedules and reaching established goals during the 35-week program. Participants with a specified number of points go on an expense-paid vacation.

81-1323
Labor Force-Employment: Provider-Policymaker Setting.
Dowling, M. T.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Provider-Policymaker Setting, 4 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

A review of the field of occupational health and of the health educator's role in the United States provides a background for developing a national policy on occupational health education. Only 1 percent of the 5 million occupational worksites in the United States employ an occupational physician. Less than 15 percent of all workers in the nation belong to a union providing a health package. A recent study indicates that there are 20-25 million job-related injuries annually. The active participation of workers and their representatives in the development and administration of educational programs, literature, and demonstration safety and health projects is crucial to the identification and amelioration of worksite-related health hazards. In all countries there is (1) a shortage of occupational health personnel; (2) a shortage of shared information about programming; (3) little education about worker health and safety in elementary and secondary school curricula; and (4) a need for clarification concerning the role of the occupational health educator.

81-1324
Health Education Program Planning for Rural Workers.
Flynn, B. S.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 15 p., June 1, 1981.
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Experiences of a health educator concerned with lung disease prevention among rural workers in Vermont provide insights into program development and implementation in this setting. The area served had about 500,000 residents, most of whom lived in towns of less than 10,000 persons. Since the majority of privately employed workers were employed by a variety of small industries, it was difficult to identify occupational health problems. Once problems were identified, programmers had to determine whether these were related to individual choices made by workers or organizational structures imposed on them. Assessing the acceptability of programs to management and workers was difficult, due again to the variety and dispersion of occupations in rural Vermont and the lack of any representative organization. Consultation with workers and a review of pertinent literature should provide health programmers with an inventory of targets for educational intervention.

81-1325
Problemas de Salud de los Trabajadores en las Americas (Health Problems of Workers in the Americas).
Villafana, C.
Paper presented at the Inter-American Symposium on Health Education, May 1 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 9 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

The United Committee of Occupational Health was established to protect and improve workers' health in the Americas. Special problems in occupational health in-

clude changes in activities and lifestyles, biotypological problems, population health standards, energy expenditures and diet, personal problems, size of industries, lack of health facilities, lack of health personnel, geographic and climatological problems, social problems, legislative problems, and occupational illnesses. To achieve occupational safety, directors, supervisors, and workers must be informed and educated in a manner compatible with production and industry in that area.

81P-1326
Safety for the Family.
Klaiber, D. P.
Armco Inc., Corporate Accident Prevention and Occupational Health, P.O. Box 600, Middletown, OH 45043
January 1979 - Continuing.

The "Safety for the Family" program is designed to promote off-the-job safety measures of Armco Corporation employees and their families. The program develops a family safety leader by providing on-the-job training for off-the-job accident prevention. The program includes a series of 12 four-page self-mailers describing home, transportation, recreation, and public off-the-job hazards and preventive practices; an attractive portfolio to store the monthly tips for future reference; an illustrated appointment calendar that reinforces the monthly safety tip; a lesson plan for each monthly safety tip to aid the safety meeting coordinator in preparing for on-the-job training of each monthly safety tip; four page flip charts to aid the supervisor in conducting training; a supervisor's manual for implementing the program; a 15-minute, 16mm film on the program for use in orienting new employees, community public relations, and supervisor training; and a 1-day management and supervisor training seminar on program administration and implementation conducted by an Armco representative. The target audience consists of all Armco employees and pensioners and their dependents. The company employs 40,000 personnel in the United States and Canada and provides benefits to 14,000 pensioners. The total target audience includes 160,000 people. The program includes a report system that covers all employees and allows comparison of accident rates before and after project interventions.

HEALTH EDUCATION METHODOLOGY

81-1327
Mental Health--Rural Setting.
Albizu-Miranda, C.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 3 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Effective mental health programming in rural areas should focus on community strengths in order to provide a basis for dealing with weaknesses. It is necessary to develop health education programming that allows rural communities maximum autonomy in dealing with their socioeconomic, educational, emotional, recreational, and health needs. Effective programming should promote the development of leaders who stimulate the active participation of community members. A competent health worker should understand the difference between the parameters of well-being in rural areas and those in urban areas.

81-1328
Multiculturalism and Nutrition Counseling.
Barer-Stein, T.
Journal of the Canadian Dietetic Association (Toronto) 40(2):112-116, April 1979.

Nutrition counseling is a familiar and vital aspect of the dietetic profession. In addition to information on nutrients and their relationship to health and disease, knowledge of cultural backgrounds is basic to understanding people's food preferences, methods of preparation, and consumption. Nutrition professionals must be aware of the cultural diversity behind Canadians' food customs, which are usually the last and most difficult indigenous roots for people to relinquish. Factors affecting food preferences include climate, history (conquests and migrations), status, and religion. Awareness of Canada's cultural diversity, the definition of an ethnocultural group, and the stages in the country's ascent to multiculturalism should be integral parts of the nutrition counselor's approach. While first and second generation immigrant groups focused their efforts on survival and assimilation, third and fourth generation Canadians and most of the post-World War II population experienced a renewal of ethnic identification, cultural diversity, and a sense of dual roots. Unlike the United States, Canada rejected the "melting pot" ideal; this rejection resulted in the 1971 official multiculturalism policy.

Western adaptations to ethnocultural meals and foods abound, but the nutrition professional must be familiar with the original traditional dishes and techniques as well. Examples are given of Japanese, Russian, and English approaches to diet. Ethnocultural food customs are part of Canadian everyday life and belong with nutrition courses. 3 references.

81-1329
Source Reduction--A Community Hygiene Approach.
Casta-Velez, A.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 10 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Refuse buildup in Puerto Rican communities has created sanitation and other health hazards that demand educational interventions to stimulate positive community response. Local health officers and other leaders should be contacted to inform them of the problem. A comprehensive survey methodology should be developed to identify the conditions contributing to environmental health problems and the areas requiring attention, and to establish priorities based on the threat to community health. Pre- and postprogram surveys should be used to evaluate the efficacy of any particular program. Small town programs can involve the entire community, while programs in large cities should be broken up into neighborhood components. Military personnel, local government agencies, and local business leaders should be involved in programming. A community motivation campaign using mass media, handouts distributed in school, church announcements, and neighborhood canvassing should begin 2 weeks before a community cleanup to allow time for households to clean their premises. Ongoing programs to clear vacant lots and demolish vacant buildings, and designation of permanent neighborhood improvement committees can be extremely effective. The most effective media adjuncts to such programs include newspapers, television, radio, exhibits or posters, leaflets, school messages, and personal interviews.

81-1330
Acciones de Nutricion y su Importancia en la Educacion Para la Salud (The Actions of Nutrition and Its Importance in Health Education).
Cerqueira, M. T.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Provider-Policymaker Setting, 9 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

All aspects of nutrition, from malnutrition to overconsumption of food, play a major role in health education. Both extremes deteriorate health and can cause significant social problems. Most studies concentrate on the biological and physiopathological aspects of nutritional problems, while social aspects are only included in descriptions of environmental conditions. The health-illness process is a collective phenomenon based on social processes, although its concrete manifestation is biological. Therefore, nutrition must be approached in terms of quantity and quality of diet and as a product of social organization. The main objective of nutrition education is to establish attitudes and habits which are conducive to adequate nutrition. This is accomplished by taking advantage of all available resources and by encouraging breastfeeding, adequate weaning, and hygiene in preparation and consumption of food. A nutrition education program should promote better cooking techniques and discourage consumption of high-priced processed foods of little nutritional value.

81-1331
Nutricion y Educacion para la Salud (Nutrition and Health Education).
Cruz Morales, C. B.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 4 p., (1981).
(Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

The nutritional status of a community and its members is affected by food availability, consumption, and use. Nutritional problems can be met with increased production of food and instruction on efficient consumption. In Mexico, the government has played a major role in increased food production and distribution. Nutrition education can be used to alter eating habits by means of mass communication, health institutions, community farming, and investigation of the nutritional value of regional food. Each member of the health team must be a health educator.

81-1332
Assertiveness Training for Adolescents: A Potentially Useful Tool in the Prevention of Cigarette Smoking.
Del Greco, L.
Health Education Journal (London) 39(3):80-83, 1980.

Recent research indicates that assertiveness training strategies enhance the efficacy of adolescent smoking cessation programs that normally have success rates of 20 to 30 percent. Assertiveness training helps adolescent smokers withstand peer pressure and peer group conformity. Assertiveness is a communication skill that teaches students to express their feelings and beliefs directly and honestly. Assertiveness training for adolescents incorporates principles of individual rights with means to act assertively in situations that relate to cigarette smoking. Central to the strategy is teaching students to understand their thoughts and feelings and the thoughts and feelings of others. After this has been accomplished, lessons concentrate on recognizing, recalling, modeling, and practicing verbal and nonverbal components of assertive, aggressive, and nonassertive behavior. Role playing allows students to practice and solidify these skills. 22 references.

81-1333
Applied Nutritional Geography: Priorities and Praxis.
Edmundson, W.
Social Science and Medicine (Oxford) 14D(2):133-137, June 1980.

Built upon the concept of "appropriate technology," i.e., technology suitable to the needs and resources of a developing country, an educational program was planned to promote the virtues of indigenous, low-cost, home remedy treatments in the early stages of vitamin and mineral deficiency diseases in East Java. Nutritional research revealed that specific vitamin and mineral deficiencies were more widespread than general malnutrition. When appropriate nutritional technologies were sought to cure xerophthalmia (an eye condition) and goiter, it was found that villagers could treat themselves by eating a mixture of papaya and cassava leaves and by rubbing their necks with tincture of iodine. These treatments were field tested, and an audiovisual nutritional education program was devised to disseminate information on self-treatment. The self-treatment program has been so effective it is expected to spread throughout Java. At present, the program lacks strong indigenous government support. Eventually, the program may serve as a model for tropical countries. A portion of the program, which involved composting, manuring, and protecting manure piles from tropical rains, failed to ameliorate low food production (a basic cause of malnutrition). The results indicate that complex projects, which require extensive effort and capital without immediate results, are less amenable to promotion through audiovisual media. While basic appropriate technologies are successful in most cases, integrated programs involving the cooperative efforts of experts, teachers, technocrats, and others offer the greatest hope for future nutritional development in the Third World. 10 references.

81-1334
Changing Breast Self-Examination Behavior.
Edwards, V.
Nursing Research 29(5):301-306, September-October 1980.

Mortality rates from breast cancer have remained almost unchanged over the past 40 years. Reversing mortality depends on early detection, and 90 percent of breast cancer is discovered through self-examination. Breast self-examination (BSE) is not widespread, however, thus indicating a need for intervention methods that facilitate early detection behavior. The effect of various behavioral intervention models on establishing and increasing the frequency of monthly breast self-examinations was examined in 130 women at the Cervical Cancer Screening Program Clinics in Utah. Four instructional methods were used: modeling alone, modeling plus guided practice, modeling plus self-monitoring, and modeling plus peer support. Followup data were collected at 3- and 6-month intervals. Data analyses revealed that the study population made statistically significant changes in BSE behavior. However, no statistically significant outcomes were related to the dependent variables of frequency and knowledge of self-examination and confidence in ability to detect breast abnormalities between subjects in the modeling alone method--which served as the control--and subjects in the other three instructional methods. Based on study data, nurses who teach BSE should incorporate the modeling method in the instructional plan, as modeling alone proved not only to be as effective as more elaborate combinations of methods, but also efficient in terms of time and materials required. Study results do not provide a clear indication of the long-term effectiveness of the modeling method. BSE is qualitatively different from other early-detection behaviors, most of which are passive activities performed at annual frequency, with diagnosis the responsibility of a professional. Further research is needed to examine these differences in early detection programs in relation to methods of instruction which lead to more enduring behavior change. 30 references.

81-1335
What to Eat and Why: The Science of Nutrition.
Fodor, R. V.
New York. William Morrow, 96 p., 1979.

An easy-to-read introduction to nutrition for elementary school readers presents the science of nutrition, nutrients,

common childhood diseases and their relation to diet, the relationship between bodily disorders and nutrition, nutritional losses that occur during food processing, and the selection of a nourishing diet. Illustrated.

81-1336
Clinic-Based Health Education: One Consortium's Approach.
Frasier, P. Y.; Beethe, S.; and Warren, P.
Health Education 11(6):43-44, November-December 1980.

In 1976 a consortium of medical and academic personnel, the Mountain Plains Outreach Program (MPOP), was organized to address the problem of attracting well-trained primary care providers to practice in rural underserved areas of Colorado. Five primary care family practice sites were developed. As one of its support services, MPOP has provided resources and technical assistance for the design of clinic-based health education programs. The key to the clinic-based health education program is the family medicine information system (FMIS), a computerized billing, record, and data system which stores and subsequently produces an age-sex registry, a diagnostic index, a practice profile broken down by provider, and a coded classification of disease as well as a cohort identification profile. Using the FMIS data base, MPOP focuses on health education for professionals and for individual patients, small groups, and the community. With the FMIS, MPOP doctors have had the capability to develop disease-specific health education programs individualized to their clinic population and the community. Technical assistance and inservice training for the clinic staff has been provided on request by the MPOP health education specialist. Some physicians in MPOP have emphasized prospective medicine or identification of risk factors for individuals based on their age, sex, and lifestyle. It is anticipated that several of the MPOP clinics will pilot usage of health risk appraisals to assess the feasibility and cost-benefit of such an approach.

81-1337
Health Education for Asians: Cultural Bridge Building.
Gray, J. and Browning, W.
Health and Social Service Journal (London) 90(4705):1042-1043, August 8, 1980.

A community health education project among the large Asian population of Blackburn, England, exemplifies the requisite coordination effort among many sectors that makes culturally sensitive, client-oriented health education possible in a multiracial setting. Overcoming the significant linguistic and cultural barriers is a two-way process; hence, bridging agents are key figures in the project. Fieldworkers need to know the religious laws and indigenous customs that affect patients' willingness and ability to accept medical advice. In English language classrooms and through home visits, teachers introduce health education modules and, in turn, learn about problems and cultural practices of the Asian group. This knowledge is incorporated into an inservice training course for health educators serving as field workers. The course increases awareness and respect for cultural differences that affect health behavior and also covers the needs and problems of health educators in general. The project plans to employ women from the Asian community as language links to transmit information on dietary practices of Asian patients to district dietitians. It is anticipated that the need for the project's bridging activities will be ongoing and will require future funding.

81-1338
Puppets in the Nursing Process.
Gustafson, M. B.
Supervisor Nurse 11(11):33-35, November 1980.

The use of puppets can enhance the interaction between nurses or patient educators and children. Hand, rod, shadow, and string puppets are each used in specific situations where they are most advantageous. In assessing patient needs, puppets can be used to win confidence, decrease fear or antagonism, establish rapport and trust, arouse curiosity, and ask or answer questions. During the planning and intervention stages of patient education, puppets can be used to allay fears, impart information, provide opportunities for expression of hostility or anger on the part of the child, and introduce new people or procedures. In evaluating the patient, puppets can provide a means of praising or reinforcing information acquisition, asking questions, stimulating thought, and reviewing knowledge. Puppets are particularly helpful in dealing with sensitive or controversial topics. 10 references.

81-1339
Counseling Elders and Their Families: Practical Techniques for Applied Gerontology.
Herr, J. J. and Weakland, J. H.
New York, Springer, 308 p., 1979.

Practical guidelines for counseling elderly clients and their families are provided for use by gerontology professionals. Topics receiving attention include the responsibilities and restrictions of the applied gerontologist, family system theory and aging, evolution of family problem solving, deter-

mination of problems within the family system and of solutions to such problems, comprehension of the family system, mobilization of the family system, and withdrawal from the family system. Case examples provide information on dealing with family confusion, intergenerational conflicts, hypochondriasis, alternative living arrangements, independence and loneliness, grave disabilities, and death and grief. Lists of readings in mental health and aging and in family counseling and family therapy are appended. Numerous references.

81-1340
Integrating Family Planning and Home Economics: Resource Handbook, Part II. Village Level.
Iowa State Univ., Ames, Coll. of Home Economics.
Washington, D.C., American Home Economics Association, 80 p., 1977.

Resource guidelines for integrating family planning and home economics are provided for use by rural fieldworkers in developing countries. Topics receiving attention include family decision making, couple communication, family roles, means of spacing children, costs of raising children, the influence of religion on family decision making, childhood and social development, parent-adolescent relationships, food supply and population, nutrition during pregnancy, infant nutrition, nutrition during childhood, and modern contraceptive methods for men and women.

81-1341
Breaking the Accident Chain.
Mackey, R. T.
Health Education 11(6):42, November-December 1980.

A model of the accident chain is an effective instructional device for helping individuals analyze the causes of many types of accidents. It is constructed using pieces of wood that represent factors involved in an accident sequence: environment, human, agent, trigger, and accident. Each of the six upright pieces representing accident factors are placed 6 inches apart, so that when any one is removed, the chain action will be interrupted when the pieces are toppled. In analyzing an accident, students consider the predisposing conditions and various ways of changing the situation to avoid activating the trigger. The accident chain model can be used in school health instruction or in an industrial setting.

81-1342
Media--It Takes More Than Flipping a Switch.
Miller, J.
Cross-Reference on Human Resources Management 10(2):6-9, May-June 1980

The use of media for health information and patient education is adding a new dimension to health care. Patient education titles in seven major media formats--16mm film, super 8mm film, videotape cassettes, 35mm slides, filmstrips, audiocassettes, and film cassettes--are currently available from commercial producers, professional organizations, not-for-profit organizations, drug and medical supply companies, universities, and the government. Commercial producers supply approximately 90 percent of all health education media programs. Due to the high cost of visual health education materials and the generalized nature of the material provided, many health educators are expressing a desire to produce their own materials. As the demand for health information by consumers increases, and as health educators and physicians utilize educational media, it is becoming increasingly important to facilitate intelligent selection and applications of available programming. Factors such as budget, the goal of the health education program (general health information or specific educational instruction), the playback setting, and media format are determinants of suitable media choices. To aid educators in the selection process, there is a growing need for professional evaluation of consumer and patient health information materials. The emphasis of such evaluations to date has been confined to continuing education programs directed to health professionals. An updated and accessible central list of consumer educational media featuring health education should also be compiled to keep abreast of the rapid increase in the volume of available materials. 3 references.

81-1343
Family Pharmacy and Family Medicine: A Viable Private Practice Alliance.
Robertson, D. L.; Groh, M. J.; and Papadopoulos, D. A.
Journal of Family Practice 11(2):273-277, August 1980.

The alliance of the new roles of the family physician and the family pharmacist is exemplified by a model private practice in a suburb of Charleston, South Carolina. A medical partnership and a pharmacy sole proprietorship, housed together in the same building, are united professionally, while remaining two separate legal and financial entities. The pharmacist works closely with the family physician to offer ongoing personalized patient education, emphasizing therapeutic indications, administration of medication, adverse reactions, and compliance. In cooperation with the physician, the pharmacist then assumes personal responsibility for routine followup monitoring of the patient's drug therapy to detect drug interactions, inadequate therapeutic response, adverse reactions, cross sensitivities, and drug overlap. The pharmacist also serves as a consultant to the physician for up-to-date drug infor-

mation and helps solve difficult therapeutic problems. Reimbursement for pharmacy services occurs for consultative time as well as by traditional methods. This collaboration can result in an effective therapeutic regimen that is individualized, cost-effective, and of high quality. An appropriate physical plant, common medical records, and ongoing communication between physician and pharmacist are essential. The team approach increases professional fulfillment for practitioners, increases knowledge and appreciation of each other's specialty, and brings positive response from staff and patients. A detailed analysis of the combined practice is premature but will be performed later in fiscal year 1980. 15 references.

81-1344
Pediatric Oncology Bibliography.
Sachs, M. and Tharp, P.
Cleveland, Ohio, University Hospitals Cancer Center, 19 p., January 1980.

An extensive reference list for children who have cancer, their parents, families, friends, and health care professionals contains materials from a variety of sources, as well as a list of cancer information resources. Entries are grouped as follows: general; hospitalization; nutrition; child development; activities and play therapy; schools, camps, and employment; books to help children understand illness and death (subdivided into sections for preschool children, 5- through 8-year-olds, 9- through 11-year-olds, and children 12 years old and older); and death, dying, and bereavement. Audiovisual materials are included in several sections of the bibliography.

81-1345
CDA's Model Dental Health Kit: Does It Work in Classrooms?
Silverstein, S. J.; Larson, S.; and Eckhaus, R.
Journal of the California Dental Association 8(1):57-60, January 1980.

A study involving 30 elementary school classrooms was designed to evaluate a dental kit developed by the California Dental Association's Council on Dental Health. The kit contained all materials necessary for one classroom to institute a 3-month dental health education unit that included a plaque control program. Each classroom received one kit, and participating teachers completed a preliminary survey questionnaire. The teachers were told to use the kit according to directions in the instruction booklets. Each teacher received a visit from the project health educator 2 weeks after receiving the kit to deal with any problems and after a 6-week miniprogram to administer a postprogram evaluation questionnaire. The preliminary evaluation revealed that 10 of the 30 teachers had provided dental education units for their children and that only 1 teacher had heard of the kit previously. Postprogram evaluation results indicated that (1) a majority of the teachers felt that the kit contained enough information; (2) several teachers felt that a short inservice program would have been helpful; and (3) half of the teachers felt that the $30 kit was too expensive.

81-1346
Information Science Contributions to Health Information.
Simpkins, J. D.
Bulletin of the American Society for Information Science 5(3):18-19, February 1979.

The contributions from information science to health information need not be restricted to effective and efficient mechanisms of distribution and dissemination; information science can address the important questions of content and form of the information to be distributed. Information science techniques which help to destandardize the message and match individual needs with information offer the greatest potential to reduce the gap between health information and health practices. A review of health education literature showed a significant tendency toward standardization of messages, both in content, treatment, and medium. Information science permits a focus on a specific audience--individuals or a subgroup of people--who have the same medical problem and share a set of knowledge requirements or information problems as well. Information science techniques and technology allow for differentiating information at a much more detailed and refined level than document titles and abstracts. The problem of access to knowledge is related to subject matter representation in vocabularies which reflect the total range of prospects for the use of the information. Three specific contributions of information science to health information are (1) retrieval of information at the fact or sentence level; (2) construction of controlled vocabularies and thesauri; and (3) development of multiple vocabularies for the same files, semantic networks, synonym tables, and similar techniques. As part of a feasibility analysis, an information system is being designed to permit appropriate responses to individual differences from a common file or data base with several different levels.

81-1347
Who Me, Addicted?
Stern, R.
Health Education 12(2):36, March-April 1981.

The Drug Dependency Inventory (DDI) was designed to help high school and college students understand drug addiction, the point at which addiction becomes destructive, possible addiction problems among themselves, and the value attached to drug-taking behavior. The DDI consists of Likert scales that assess the student's physical, social, and psychological motivations for drug use or abuse. After the student anonymously completes the DDI, average scores can be computed and the meaning of these scores discussed. An application of the inventory in a drug studies workshop at the State University of New York at Cortland indicated that psychological dependency indicators exceeded social dependency indicators, and both of these indicators exceeded physical indicators.

PATIENT EDUCATION

81-1348
Medication Group for Psychiatric Patients.
Cohen, M. and Amdur, M. A.
American Journal of Nursing 81(2):343-345, February 1981.

A medication group was organized at two outpatient psychiatric programs to insure medication compliance among patients. A problem-solving, task-oriented approach helps clients gain insight into their own feelings about taking medication. Weekly meetings, which have a question-and-answer format and involve 6 to 10 clients, are led by the staff psychiatrist and the agency nurse. During the 4- to 6-week program, clients share drug-related experiences and information about dosages, drug indications, and mental illness. Patients who seem to lack sufficient knowledge are given assignments that will contribute to their drug knowledge. Clients are more likely to perceive their medications in terms of side effects rather than therapeutic effects. Group members provide reassurance, while group leaders provide information. Testimonials by members who have been hospitalized after discontinuing medication reinforce the need to comply with medication regimens after symptoms have disappeared. The group situation is particularly effective in clarifying misconceptions associated with depression.

81-1349
Recall of Health Education Display Materials.
Cole, R. and Holland, S.
Health Education Journal (London) 39(3):74-79, 1980.

A 15-item questionnaire was designed, pilot tested, and administered to 198 women to determine whether they noticed a poster displayed in the waiting area of a health center promoting cancer examinations for women. The display included two identical posters and some leaflets detailing the cancer test. Analysis of the women's responses indicated that 67.7 percent remembered the picture, 50 percent remembered the television character represented, 18.7 percent remembered the exact wording, only 26.3 percent remembered the correct color of the poster, 47 percent remembered a portion of the message, and most of the women who recalled the picture also recalled the wording. Of the 16 women who scored highest on the questionnaire, only 4 took the leaflet home or read it in the office. Of all the women in the survey, 90.4 percent did not read the leaflet and 92.7 percent did not take one home. Recall of the display was not related to patient's age or waiting time. Results suggest that literature should be disseminated directly by professionals and that short messages and appealing illustrations enhance posters and other literature.

81-1350
Effectiveness of Patient Education (Letter).
Crouch, M. A.
Journal of Family Practice 12(1):22-25, January 1981.

Methodological limitations render questionable the conclusions reached in the study "Effectiveness of Patient Education and Psychosocial Counseling in Promoting Compliance and Control Among Hypertensive Patients" (Journal of Family Practice, 10:1047, 1980). The conclusions that health education and counseling are not cost effective may have been hastily drawn. The original article gave no data regarding the base-line pill count rates versus postintervention rates. The methodology described included no explanation of how pill count compliance was calculated in the combined pill-bringing and pill-consuming rating for visits where the patient did not bring the medication. No mention was made of the number of blood pressure measurements taken on each visit, and the researcher took only diastolic blood pressure readings. Educational interventions were provided only once a month. These criticisms can be answered in terms of findings that blood pressure measurements are more valid indicators of compliance than pill counts and that diastolic blood pressure is generally considered to be more closely correlated with organ damage. Finally, though the results of the study cannot be generalized to other patient groups, it is true that the three monthly, 1-hour intervention sessions failed to help this population of long-term uncontrolled hypertensives. Patient memory and understanding of health education can be improved if the physician

writes recommendations or a checklist for the patients to take home and questions the patients to determine their level of understanding. 4 references.

81-1351
Discussion Paper on Patient Education in Urban Settings: "The Health Cycle and Individual Decision Making" ("El Ciclo de Salud y el Proceso de Como el Individuo Hace sus Decisiones").
Deeds, S. G.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 3 p., (1981).
(Spanish and English).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

The health cycle can be divided into four sequential, overlapping, and simultaneous stages with regard to decision-making processes. The stages are associated with prevention and self-care, initiation of treatment, continuation of treatment, and self-management. Decisions made at each stage involve input by family and friends, organizations, and the general community. Each stage has a major focus for the decision making and for different combinations of influencers that are sources of reinforcement and support. Indepth research should be done on the maintenance of long-term, self-monitoring behaviors.

81-1352
Tips for Your Fractured-Jaw Patient.
Geisler, J.
RN 44(1):33, 114, January 1981.

Patient education for persons with fractured jaws should include components to deal with the possible malnutrition, dental problems, depression, and panic that can accompany the treatment of jaw fractures. During the 1- to 3-day hospital stay for setting and immobilizing a fractured jaw, patients must be instructed in the (1) use of dental waxes and petroleum jelly to pad mouth braces and prevent sore lips, (2) prevention of and proper reactions to nausea, and (3) use of a food blender to prepare liquid and semiliquid food. Patients must be aware that weight loss of 6 to 20 pounds during the 6- to 9-week mending period must be expected. Patients can minimize weight loss by eating small, frequent, high-calorie meals. Though some tooth decay is inevitable, proper use of a soft toothbrush or an appliance using pressurized water will minimize decay. A thorough dental checkup is necessary immediately subsequent to removal of the jaw wires. Upon removal of the wires, patients should be instructed to eat soft foods, perform certain isometric exercises, and understand that their teeth will feel loose for a short time.

81-1353
Consolidate Patient Teaching Resources.
George, G.
Health Care Education 9(3):1, 17, 20, August-September 1980.

Utilizing a patient teaching manual is one approach to facilitating patient teaching. The manual is an alphabetized reference tool, containing one copy of all patient handouts currently in use, as well as guidelines for teaching and other pertinent reference material for the staff. All teaching materials for each type of health problem are included in this reference source. The effectiveness of the manual depends on its structure, its location, and an adequate storage system for materials to be disseminated to patients. Widespread distribution of the manual, supplemented by inservice activity, provides a firm foundation for hospitalwide, decentralized patient teaching.

81-1354
The Organisation and Management of Patient Training Services at Darenth Park Hospital.
Gillott, J. S.; Qazi, H. S.; Quigley, J.; Vyse, J.; Hooley, A.; and Humble, D.
Hospital and Health Services Review (London) 74(3):77-81, March 1978.

During the past 3 years, the Darenth Park Hospital for the mentally handicapped in Kent, England, has developed an effective patient training organization to better utilize the industrial working potential of the patients. Using a corporate approach, planners developed a structure that allowed different professionals to contribute towards the training and education of patients. Initially, a multidimensional activities team consisting of a consultant, the principal nursing officer, a hospital secretary, the coordinator of adult patient training and education, and a senior clinical psychologist produced a detailed policy statement. The team decided that there should be a graduated training and work scheme allowing patients to move up or down according to their potential. Multidimensional educational centers were developed for specific groups of patients with similar educational levels and needs. Each center provided resources to help the patient practice a full range of self-help, communication, socialization, and occupational skills. Multidisciplinary teams, organized corporately, staffed each center. A residents' employment and training team mediates between the activities team and

the center teams, providing a forum for discussion and practical help in implementation. An overall program coordinator oversees the entire program, while activity leaders oversee educational teams at specific centers. A formal program of staff meetings was organized to inform and organize staff. The organizational structure has proven flexible in all areas of organization and delivery.

81-1355
Teaching Young Patients--And Their Families--About Home Peritoneal Dialysis.
Gross, S. and Algrim, C.
Nursing 10(12):72-73, December 1980.

The Home Dialysis Training Center of the University of Colorado offers a home dialysis program for children. Though the process requires 36 to 49 hours per week, as compared to 15 hours per week for hemodialysis, peritoneal dialysis can be performed while the child is sleeping. Medicare pays for 80 to 100 percent of treatment costs and patient and parent training costs. Participation of the affected children in their own care is essential and requires a 2- to 4-week training period for the patient and the family. The training program focuses on medical implications of end-stage renal disease, psychological implications, and technical aspects of dialysis. The family is evaluated by every member of the health care team, including the physician, nurses, technicians, nutritionists, social workers, and psychiatric consultants. A home visit by a nurse during the first dialysis treatment allows for followup of the training program. Continued education and counseling are provided to the patient during followup visits to the clinic.

81-1356
Diabetes Education in Kansas.
Guthrie, R. A. and Kyner, J. L.
Journal of the Kansas Medical Society 81(6):289-291, 300, June 1980.

Every health professional should have a basic, up-to-date knowledge of diabetes as well as an awareness of resources for specialized consultation and followup evaluation. A variety of facilities offer education programs for patients and medical personnel in the Kansas City and Wichita area and other locations within the State. Among these are the Kansas Regional Diabetes Center, the Cray Diabetes Education Center, the Endocrinology Section of the Department of Pediatrics at the University of Kansas School of Medicine, and the Internal Medicine Diabetes Outpatient Clinic at the University of Kansas Medical Center. The University of Kansas plays an important role in many patient and professional education programs through the provision of funding, faculty and staff, and resources. Other diabetes projects are supported by various community and volunteer organizations. The American Diabetes Association performs an important advisory and coordinating function in research and education for the patient and the community. Programs for physicians are provided in a number of formats ranging from the traditional circuit course program to physician participation in hospital or medical center teaching programs as an active observer. Nurses training is also important since they as nurses are assuming increased responsibility for patient instruction. Coordination of educational efforts among the universities, the communities, the hospitals, physicians and other professionals, and patients makes the task of diabetes management easier for all involved. A list of contacts and resources is given.

81-1357
Diet and Diabetes.
Heinze, F. L.
Journal of Practical Nursing 30(1):23-24, January 1980.

Teaching diabetics about the dietary requirements of their condition should be integrated with instruction in all areas pertinent to control of diabetes. If possible, dietary changes should be based on patients' current eating habits and lifestyles. They should be encouraged to avoid concentrated sweets and should be reminded that more exercise will require more calories and possibly less insulin. The length of time that a patient has had diabetes is not always an indication of the patient's knowledge about the disease and its control. Thus, the nurse and dietitian should determine the patient's knowledge before instruction. Having patients keep records of diet and activity and constantly engaging them in group or one-to-one discussions can significantly improve compliance with the prescribed regimen.

81-1358
Five Principles of Patient Education.
Huntley, D. E.
Dental Hygiene 53(9):420-423, September 1979.

Patient education is fundamental to dental hygiene practice. Patients' learning in a plaque control program is most appropriately assessed by changes in the patients' behavior patterns. These changes can be facilitated by presenting information in small amounts at one time, letting patients set their own pace, supervising the patients' practices, providing immediate feedback, and using positive reinforcement. 31 references.

81-1359
Rehabilitation of the Patient with a Spinal Cord Injury.
King, R. B. and Dudas, S.
Nursing Clinics of North America 15(2):225-243, June 1980.

A major aspect of the nursing care of patients with a spinal cord injury is helping them to accept their altered body image and altered body functioning and to cope with the demands of a prolonged, intense rehabilitation program. As patients progress through the stages of rehabilitation, discharge, and community living, they assume increased responsibility for and control of their own care. Patient education during rehabilitation helps the individual implement positive choices about actions required to maintain health and provides feedback and reinforcement for appropriate choices. Factors involved in patients assuming increased responsibility are participation in goal setting, knowledge of the rationale for care measures, and specific instruction in all aspects of care, as well as in alternative methods for achieving goals and solving problems. Regular interdisciplinary conferences that include patients and their families are necessary, since so many disciplines are involved in rehabilitation. Patients need to receive instruction in the areas of respiratory function, skin care, bowel and bladder control, sexuality, and possible complications. Teaching the activities of daily living is coordinated with the patient's progress in other therapy departments. Groups composed of the families of patients with a spinal cord injury are helpful in providing mutual support. The ultimate long-term goal of nursing care and patient education is to enable patients to re-enter the community, resume a social life, and achieve an optimum level of independence in the activities of daily living. 8 references.

81-1360
Patient Education and the Audit.
Kuehnel, C. and Rowe, B.
Supervisor Nurse 11(12):15-19, December 1980.

The Nursing Department at Midway Hospital in St. Paul, Minnesota, developed a teaching tool using the Kardex filing system. The tool was developed in response to needs for better documention of patient education. Observation of existing chart forms indicated confusion concerning the proper means of documenting patient education and limitations of space for nurses to record outcomes or objectives. An 8-inch by 11-inch Kardex format replaced the original 5-inch by 8-inch Kardex and the format was distributed throughout the nursing staff for comments and revisions. Once the final format was authorized, inservice sessions reviewed their use. Information stickers were used when documentation was overly repetitive. Audits of patient teaching before and 2 weeks after the inception of the new format indicated improved nurses' documentation of patient teaching.

81-1361
A Key to Compliance: Systematic Teaching to Help Hypertensive Patients Follow Through on Treatment.
Loustau, A. and Blair, B. J.
Nursing 11(2):84-87, February 1981.

The hypertension clinic at the Veterans Administration Medical Center in Seattle, Washington, has developed a systematic patient teaching plan that can be used in a hospital, office, or home. The teaching plan relies on a chart consisting of 23 objectives associated with hypertension control. As the clinician discusses each topic with the patient, the adequacy of the patient's knowledge is indicated on the chart. Rote learning is avoided, and a conversational tone is maintained. The first 10 objectives on the chart address hypertension, stressing the lack of symptoms and hypertension's chronic nature. Objective 11 encourages patients to have their families checked for hypertension. Objective 12 helps the patient to understand the goal of treatment, specifically, to realize optimum diastolic blood pressure. The remainder of the objectives deal with the regimen and means of adhering to it. Keeping appointments, maintaining a regular exercise regimen, reporting side effects, understanding medication regimens, and altering dietary and other lifestyle habits receive steady attention. 6 references.

81-1362
How to Increase Compliance in Hypertensives.
Lowther, N. B. and Carter, V. D.
American Journal of Nursing 81(5):963, May 1981.

Since the first step in achieving long-term control of blood pressure is helping hypertension patients keep followup appointments, the Department of Medicine's Hypertension Program at the University of Cincinnati's College of Medicine instituted a "tickler" file of all patients in 1977. Each patient's name, chart number, address, phone number, and date on which an appointment was kept or missed are recorded. During the experimental phase, reminder cards were mailed to patients within 5 days of missed appointments. The number of patients who did or did not reschedule appointments within 3 months of receiving the reminders was tallied. Similar data were kept for a matched period at the clinic during which no reminders were mailed. Chi-square analysis of the data revealed that a significantly greater number of patients rescheduled appointments during the period in which cards were

mailed and that patients were significantly more likely to comply with prescribed treatments during the period in which cards were mailed than during the matched period when no reminders were mailed.

81-1363
Self-Produced Videotapes Aid in Home Instruction.
Magill, G.
Physical Therapy 58(9):1092, September 1978.

The Physical Therapy Department and the Audiovisual Department of St. Luke's Hospital in Fargo, North Dakota, have collaborated on the production of videotapes supplementing instruction by physical therapists. The 3- to 10-minute tapes prepare the patient and the family for individualized instruction and evaluation by physical therapy staff. The videotapes have increased the uniformity and clarity of instruction, reduced the need for constant repetition of instruction, and resulted in more efficient use of staff time.

81-1364
Planning a Hospital-Based Patient Education System.
Magill, K. A.
Hospital Topics 58(3):20-23, May-June 1980.

Most health care professionals now recognize patient education as an integral component of health and illness care in primary, secondary, and tertiary care settings. An ideal model of patient education in a hospital setting is offered as a stimulus for thoughtful planning. Realistic matching of population needs, budgetary considerations, provider teaching skills, and available methodologies and technologies is an important part of the planning process. Once needs, resources, and key personnel have been identified, decisions need to be made concerning centralized or decentralized structure, extent of multidisciplinary and consumer involvement or noninvolvement, lines of communication, and the authority and responsibility associated with different roles. Manuals for professional staff should contain key policy statements of beliefs, goals, objectives, organizational structure, operational guidelines, and evaluation methodologies. A key concept underlying the model is to promote multidisciplinary agreement and cooperative reinforcement of teaching efforts. A multidisciplinary teaching team plan-and-evaluation system might function on each patient unit and would utilize both health professionals with additional academic preparation and expertise in education and direct care providers. Nurses are in a key position to promote, reinforce, and coordinate complementary health team teaching. Given the current state of the art of patient education in hospitals, it is essential that agencies pilot and evaluate different models of patient education delivery systems. Schematic representation of this patient education model is available upon request. 4 references.

81-1365
Patient Education--Rural Setting.
McLaughlin, J.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 6 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Patient education issues in rural areas are discussed. Rural setting characteristics that influence patient education services include small hospitals, the unwillingness of the populace to seek preventive care, the large number of elderly persons, high infant and neonatal mortality rates, high accident rates and occupational injuries, and high rates of mental illness and alcoholism. Medical personnel are generally in short supply, and insurance coverage for rural residents is lacking. To solve problems associated with understaffing, many rural hospitals have begun to use nurse practitioners and physician assistants to provide patient education services. Rural health corporations and comprehensive care clinics have scheduled classes for identification and education of persons with chronic illnesses. Team approaches to teaching and the use of audiovisual aids have benefited these programs greatly. Family planning and nutrition education programs can be offered in a similar manner. Local health fairs and other outreach efforts can be staffed by various clinic personnel. Overall, a diversity of programs, some affiliated with the rural hospital and some maintaining liaisons with it, should be developed in an organized comprehensive network.

81-1366
The National High Blood Pressure Education Program's Information and Education Strategies for Public and Patient Audiences.
National High Blood Pressure Education Program (DHHS, NIH), Bethesda, Md.
Bethesda, Md., the Program, 9 p., January 1979.

The National High Blood Pressure Education Program has developed an information and education strategy to reduce hypertension in 35 million Americans. The program stresses the asymptomatic and chronic nature of high blood pressure, the benefits of controlling high blood pressure, the need to combine medication and behavioral

change to normalize high blood pressure, and the need for support from family members. The primary target group consists of people diagnosed as hypertensive, while the secondary target group includes the families and friends of such people. Educational strategies used in the program should cultivate physician-patient relations, avoid scare tactics, and emphasize that hypertensives can lead normal lives if they bring their condition under control.

81-1367
Increasing Compliance: Patient-Operated Hypertension Groups.
Nessman, D. G.; Carnahan, J. E.; and Nugent, C. A.
Archives of Internal Medicine 140(11):1427-1430, November 1980.

A study involving 51 men and 1 woman with inadequately controlled hypertension analyzed the effectiveness of a nurse-operated hypertension clinic of a patient-operated group in inducing patient compliance with the prescribed regimen. Each patient education program was implemented over an 8-week period. Control patients in the nurse-operated clinic listened to audiotapes on hypertension and its management and met individually with a nurse who adjusted their drug regimens. Experimental patients in the patient-operated group were trained to take their own blood pressure and select their own drugs in a group program emphasizing informed self-help. After the 8-week training period and at 2- and 6-month follow-up visits, both groups had significantly lower blood pressures. Compared with the control patients, experimental patients had lower diastolic blood pressures, better pill counts, and better attendance records. These results suggest that training noncompliant patients in groups to manage their own hypertension may achieve better results than traditional management approaches. 10 references.

81-1368
Improving Patient Teaching With an All-In-One Program.
Raymer, M. C.
Nursing 10(8):18-19, August 1980.

Staff nurses at the Infection Control Unit of the Veterans Administration Medical Center in Hot Springs, South Dakota, designed a patient education program that consists of instructional materials on specific diseases. These materials are packaged in convenient folders, and each folder contains a guide to the patient teaching program, a step-by-step teaching outline, printed handout materials, a list of audiovisual materials, and an evaluation instrument. A patient teaching group, comprised of nurses, meets regularly and divides into subgroups to address specific diseases and develop the educational folders. The folders are routed through appropriate hospital channels for approval.

81-1369
Patient Education. Fad or Reflection of Changed Standard of Care? (Editorial)
Redman, B. K.
Archives of Internal Medicine 141(2):163, February 1981.

Hospital surveys indicating rapid expansion of patient education programs reveal controversy over research, delivery, and patient-provider responsibility. Health professionals disagree over whether patient education is an improvement of care based on humanistic concerns or an instrument that ought to be adopted only if its efficacy is proven. It is also not clear whether patient education should be provided by specialists or direct-care providers. The balance of responsibility between individual patients, providers, health care agencies, and society is also at issue. Some concerns include present incentive systems that pay for services regardless of the patient's ability to avoid those health problems and the "blame-the-victim" approach, which avoids societal responsibility. Regardless of the outcome of these debates, it seems that health care institutions and providers will be forced to expand their educational services, and that there will be pressure for justification of patient education and empirical research in the field. 3 references.

81-1370
Advising Patients on Sex After Surgery.
Robusto, N.
AORN Journal 32(1):55-61, July 1980.

Patients recovering from abdominal surgery should be provided with information and counseling regarding post-surgical sexual activity. Unit nurses and operating room nurses are in key intervention positions. The surgical healing process should be explained to the patient, and 4 weeks should be suggested as the normal period to refrain from sexual activity after abdominal surgery. Healing of a small incision may progress fast enough to allow sexual activity after only 3 weeks, though major incisions for procedures such as colon resections require 4 to 6 weeks of sexual abstinence. Nurses and other professionals who are responsible for sexual counseling should use one or more of the available sexual evaluation models to assess the adequacy of their knowledge and attitudes. The nurse should be able to counsel patients of all ages and sexual preferences concerning how they can return to presurgery sexual activity levels. 12 references.

81-1371
Evaluation of an Inpatient Educational Program for Coronary Patients and Families.
Scalzi, C. C.; Burke, L. E.; and Greenland, S.
Heart and Lung 9(5):846-853, September-October 1980.

A 2-year quasi-experimental time-series study involving 32 patients treated in the coronary care unit of a 800-bed university teaching hospital in Los Angeles, California, was designed to evaluate an inpatient educational program for the patients and their families. All subjects in the 19-patient experimental group participated in an organized educational program that addressed disease process, emergency treatment, physical activity, diet, smoking, psychological factors, sexual activity, and lifestyle problems. Experimental patients also received a packet of printed educational material. Control patients received neither intervention and were instructed to refer their questions to the appropriate member of the health care team. A pretested teaching evaluation questionnaire was administered to all subjects before and after the program. The Beck depression inventory was used to identify the presence and degree of depression. The patients were also administered a denial scale, coronary behavior questionnaire, a medical followup inventory, and a knowledge and compliance inventory. Analysis of resulting data via a two-sided test, the Kruskal-Wallis rank-sum, and multivariate techniques indicated that (1) experimental subjects did not improve their knowledge significantly; (2) experimental patients exhibited greater levels of depression than control patients (although the depression scores were within normal range for most members of both groups); (3) compliance to the prescribed regimen was poor for all subjects; and (4) continued instruction after discharge improved knowledge and "reported" compliance among experimental patients. 11 references.

81-1372
Individualized Diabetic Education: Doing It Better.
Sisson, R.
Michigan Hospitals 16(5):10-11, May 1980.

Staff at Saline Community Hospital in Michigan have developed a diabetic education program that emphasizes recognition of patient individuality and supportive staff-patient relationships. One aspect of the program focuses on the effects of both physical and emotional stress on blood sugar levels and on methods to prevent and manage stress. The program was designed and is administered by a multidisciplinary team consisting of a nurse, a dietitian, a pharmacist, and physical and occupational therapists. A preliminary assessment of learning capabilities and emotional readiness to learn is an important element of the program. Four 1-hour class sessions are available weekly to inpatients, outpatients, their families, and other interested community members. Skills such as insulin self-injection, urine-testing, daily foot care, and menu planning are taught. Education is reinforced by continued interactions between nursing staff and patients. The patients' understanding of diabetes, proper self-management, and good lifestyle habits is evaluated by weekly posttests, class session evaluation, and posthospital survey letters. Patients have expressed a high degree of satisfaction with the program. Ongoing quality assurance studies help in monitoring teaching effectivess.

81-1373
Patient Education in the Urban Setting (Educacion a Pacientes en el Ambiente Urbano).
Squyres, W. D.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 6 p., June 5, 1981.
(Spanish and English).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Health education is a specific set of formal, planned, educational services that help people make positive changes in their lifestyles to protect or improve their health. Numerous studies have attested to the effects of environmental and behavioral factors on health status. The major categories of health education services include patient education, health promotion, and health information services. Health education programs are taught by physicians, nurse practitioners, registered nurses, dietitians, physical therapists, and pharmacists. The Kaiser-Permanente Medical Care Program provides numerous health education services to its clients. In addition to health education during routine care, staff provide classes and other program interventions held in the Kaiser-Permanente facilities and around the community. Between 20 and 30 instructors conduct formal patient education programs at each of 13 centers, 12 of which employ health education coordinators with master's degrees in health education. Health promotion programs in the area are sponsored by Kaiser-Permanente, community colleges, voluntary health organizations, and commercial concerns. Forty-six programs are offered in either group or individual formats.

81-1374
Patient Education: Provider-Policy Theme.
Stout, N.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puer-

to Rico. Provider-Policymaker Setting, 8 p., June 3, 1981. Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Major issues related to policy making in patient education--assurance of quality, cost analysis, financing, organization and management of programming, and roles of the health education personnel force--are discussed. Criteria have been developed by numerous sources to assess the quality of health education practice, planning, programming, evaluation, and research. Health professionals need to analyze the cost of education and communication time, planning time, and support resources. A study by the American Hospital Association in 1978 indicated that 650 hospitals in the United States had budgets for health education, though only 573 of these institutions reported line-item budgets. The basic types of health education that receive reimbursement are patient education that is integral to care, preventive patient education, and community health education. Major sources of payment for health education services are third-party payers, prepayment sources, consumers, government programs, public and private grants and contracts, and gifts. The American Public Health Association Program Planning Model describes institutional planning, programmatic planning, and individual planning as the three basic levels of organization. The National Center for Health Education has instituted a survey to aid in the delineation of roles related to health education practice.

81-1375
Hemodialysis Home Training Manual for Experiment in End-Stage Renal Disease.
System Sciences, Inc., Bethesda, Md.
Bethesda, MD., System Sciences, Inc., 165 p., April 1978. NTIS; Order No. PB81-121 550.

Guidelines for training hemodialysis patients at home are provided for nurses and other patient education personnel. The guidelines were compiled from the combined resources of the 15 dialysis facilities participating in a demonstration to establish minimum training requirements. The curriculum is designed to be taught as a 4-week program with teaching periods on 5 days each week. The guidelines address the patient and self-care information, vascular access and care, and the dialysis machine and related procedures. Specific topics addressed include the shunt and the fistula, renal diet, medication, medical aspects of kidney failure, functions of the artificial kidney, and procedures for hemodialysis. Sample copies of patient monitoring record forms, home dialysis authorization, a checklist for skills and knowledge, quizzes, a final exam, and a followup visit test are appended.

PROFESSIONAL EDUCATION AND TRAINING

81-1376
Preparing Pharmacist Health Educators.
Fedder, D. O. and Beardsley, R. S.
American Journal of Pharmaceutical Education 43(2):127-129, May 1979.

A health education course for pharmacy students was developed in 1976 at the School of Pharmacy of the University of Maryland. The goal of the seminar is to provide students with the knowledge and skills needed to be an effective health educator to patients, other health providers, and the community. Readings and discussions deal with patients' understanding of the need for health care, patients' perceptions of symptoms as they relate to disease, the role of patients' attitudes and values in their motivation, communication and persuasion in educational strategies, counseling and interview techniques, educational assessment and evaluation procedures, interprofessional programs, and community health programs. Emphasis is placed on the use of the educational diagnosis of individual and community health problems. Two appendices giving the course outline and reading list are included. 13 references.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-1377
Health Education and Public Policy in the United Kingdom.
Horner, J. S.
Community Medicine (Bristol) 2(3):229-235, August 1980.

In a 1979 report, the Royal Commission on the National Health Service placed health education within an overall national strategy for health care in Great Britain, with training in health education receiving high priority. Health education requires a large investment in technical resources and professional skills. Health education officers must be able to synthesize and evaluate health information obtained from various sources. The relationship between health education officers and physicians is significant; the health education officer has access to the information needed through the community physician and implements preventive strategies. Uncoordinated

central policies result in confusion, contradiction, and a progressive alienation of the community from its public policy makers. A coordinated strategy is needed in which individual departmental programs work towards an overall central policy. Political responses alone, as well as a strictly educational approach to health problems, have been largely inadequate in such areas as smoking, alcohol abuse, accident prevention, and nutrition because they ignore the complex processes involved in behavioral change. The conflict between health education and commercial interests is a major factor. Health warnings and legislative restrictions are important public policy interventions. A balance between political activity and health education is necessary; policies of community action should be developed using legislative, fiscal, and other means. The history of Great Britain shows clearly that a combination of health care professionals and public policy makers can produce major changes in social policies, and eventually, improvements in public health. 23 references.

81-1378
Promoting Informed Consent.
Perin, G. A.
Topics in Clinical Nursing 2(4):61-65, January 1981.

Though informed consent is most frequently defined in legal and ethical terms, it may be more useful to consider what is meant by educated informed consent. This is particularly true in pediatric oncology units, where clinical trials and experimental treatment are frequent and where parents will need to give their consent. The Declaration of Helsinki and the U.S. Department of Health and Human Services have defined informed consent as explanation of the proposed treatment, explanation of the inherent risks and benefits, provision of alternatives to the proposed treatment, provision of adequate time for patients' or parents' questions and discussion, and provision of an option to withdraw from the treatment at any time. Studies have demonstrated that physicians' fear of sharing treatment information has contributed to ignorance and misunderstanding among patients. Interfering with informed consent are emotional stress; misconceptions by parents, families, and nurses; and the authority associated with a treatment protocol approved by a powerful human rights committee. Although obtaining informed consent is not a nurse's legal responsibility, nurses have increasingly participated in the consent process. The pediatric oncology nurse, who generally builds a relationship with the family and the health team throughout diagnosis and treatment, is in the optimum position to educate the family and provide members with understandable consent forms, including copies for their own use. 6 references.

RESEARCH AND EVALUATION

81-1379
A Peer Mediated Approach to Drug Education.
Bell, E. V.
Journal of Negro Education 47(3):283-289, Summer 1978.

Analysis of interviews with 298 male and female adolescents living in various parts of New York City compared the effectiveness of teenage interviewers and adult interviewers in obtaining information on drug use from teenagers. The analysis of the tape-recorded interviews was designed to determine the amount of information secured, type of information, type of personal and social explanations for drug use, type of explanations as to the availability of drugs, and background characteristics among drug abusers. Two researchers rated two tapes for each interviewer; the results were analyzed using the constant comparative method, coefficient of reproducibility, chi-square test, and standard error of the difference between two uncorrelated percentages. The analysis indicated that (1) teenage interviewers secured significantly more information from teenage drug users; (2) social and environmental explanations of drug abuse were not significantly different across interviewers; and (3) peer acceptance was central to the significant relationship between personal and social explanations and drug abuse.

81-1380
Varying the Timing of Information to Alter Preoperative Anxiety and Postoperative Recovery in Cardiac Surgery Patients.
Christopherson, B. and Pfeiffer, C.
Heart and Lung 9(5):854-861, September-October 1980.

A random study of 41 white, male patients requiring coronary artery bypass grafting assessed the impact of an educational booklet designed to provide information on the surgical experience. The 16-page booklet covered preoperative tests and procedures, expected postoperative behaviors and experiences, and information about the heart and atherosclerosis. The sample population was divided into three groups: two groups were given the booklet but only one chose to read it; the other group did not; and a group that was not given the booklet. Those who read the booklet, read it prior to surgery. The State-Trait Anxiety Inventory and a knowledge questionnarie were used to assess patients response to the booklet. These instruments were administered to the patients after being informed that they would need surgery, 1 to 2 days before surgery and 7 to 10 days after surgery. Following adminis-

tration of the questionnaires, a 10-minute interview was conducted with each patient. Analysis of the data indicated that (1) patients who read the booklet increased their knowledge significantly; (2) readers paid more attention to information that directly pertained to their treatment; (3) patients who read the booklet just prior to the operation exhibited the lowest anxiety levels; and (4) patients who did not read the booklet required longer hospitalization. 19 references.

81-1381
Alcohol in Teenage Cultures: A Materialist Approach to Youth Cultures, Drinking and Health Education.
Dorn, N.
Health Education Journal (London) 39(3):67-73, 1980.

A materialist approach to youth culture research (focusing on how young persons respond to the social and economic structure of a local area) was designed to assess alcohol abuse among midteen, working-class school dropouts living in the "downtown" borough of London, England. The strategy involved researching the local labor market, interviewing local employers and visiting local workplaces, interviewing career teachers in high schools, and interviewing 15- and 16-year-olds in several schools. Students in this age group are often making the transition from school to work in the service sector of the labor market, and, hence, they mix with other 14- to 20-year-olds who are making or have made the transition. By buying a round of drinks for fellow workers, teenagers confirmed their collective identity; girls affirmed their equality and financial independence in this manner. The traditional peer pressure model of adolescent drinking implied group dependence on dominant individuals, whereas working teenagers drank to express independence. Thus, the major forms of alcohol education that focus on self-image, values, and socialization of the individual will continue to prove ineffectual when applied to adolescents working in the service sector. More realistic and effective educational methods could be developed from a materialist model of health that examines the interrelationships among material conditions, collective culture, and recreational patterns. 7 references.

81-1382
A Self-Scoring Five-Question Risk Test for Coronary Heart Disease.
Dyer, A. R., et al.
Circulation 60(4):914-920, October 1979.

A simple, five-question risk test for coronary heart disease (CHD) has been developed to allow individuals to estimate their risk of CHD. The questionnaire requests information on smoking habits, history of diagnosis and treatment for high blood pressure, weight, pulse, and family history of CHD. The scoring system was developed from the 17-year CHD mortality study of 1,899 white males, between 40 and 55 years old, from the Chicago Western Electric Company study. The system was applied to the men of that study and predictively to 1,158 white men, between 40 and 59 years old, who were followed 15 years in the Chicago Peoples Gas Company study. In these two studies, the men in the highest quintile of risk scores had more than four times the observed numbers of CHD deaths as the men in the lowest quintile of risk scores. In addition, a test that uses actual blood pressure instead of treatment status and includes serum cholesterol level has also been developed for use in cases where the values of these variables are available. Although the scoring system for these tests is based on the mortality experience of middle-aged white males, the tests should have approximate validity for all age-sex-race groups because the scores are a measure of relative risk. 24 references.

81-1383
Health Education Evaluation: An Alternate Research Paradigm.
Gebhardt, M. E.
Evaluation and the Health Professions 3(2):205-210, June 1980.

A major disappointment with health education evaluative research is the frequent outcome of "no significant difference" or "no effect." Knowledge and attitude changes are easily measured; behavioral changes present more difficulties. Qualitative methodology is an inadequate source for data collection, systematic evaluation, or theory construction. The persistent failure to uncover statistical differences continues to plague evaluators, when experiential evidence indicates some very desirable results. Traditional methods of evaluation which equate statistical tests of significance with social importance are increasingly being called into question. The nearly exclusive reliance on the experimental approach, or scientific method, belies the qualitative grounding of quantitative research. Evaluators are now presenting theories to explain the "no effects" phenomenon, and proposing innovative alternative methodologies and qualitative data collection strategies to measure changes in human behavior, attitudes, and inner perspectives. The overall evaluative objective is to provide a comprehensive holistic analysis derived from a cross-validation of appropriate quantitative and qualitative methods. Health educators should acknowledge the existence of an alternate research paradigm as well as develop working knowledge of

qualitative data methodologies, their possibilities and their limitations, to encourage evaluation of health programs which have traditionally been classified as not feasible. 13 references.

81-1384
The Malformed Newborn--Telling the Parents.
Ives, E. J.; Henick, P.; and Levers, M. I.
In: Risk, Communication, and Decision Making in Genetic Counseling. Epstein, C. J., et al., eds. New York, Alan R. Liss, Inc. (Birth Defects: Original Article Series, Volume XV, Number 5C). p. 223-231, 1979.

A study was designed to determine if genetic counseling, added to available medical and other supportive services, would significantly influence the family's management of specific aspects of family life likely to be influenced by the birth of a malformed infant. Differences were measured between an experimental group of parents who had received genetic counseling and a control group who did not. A questionnaire administered separately to husbands and wives in both groups requested basic information about the respondent and family as well as a number of areas of concern to the parents, such as knowledge of the child's deformity and its implications, reproductive plans, and beliefs about risk of recurrence. Several questions were included on the circumstances in which parents received information of their infant's deformity, as well as parent's satisfaction with the manner in which this information was provided. Preliminary findings are presented in 10 tables. Although differences between the experimental and control families are inconclusive at the present stage of analysis, areas needing change include the way in which the father of a malformed infant receives the information, as well as the wording and content of many explanations provided to parents. Mothers and fathers of malformed infants should receive the information together, in a private environment, with supportive people available and opportunity for early followup discussion. The effect of parental involvement with a genetic counseling service in the process of adjustment to a malformed infant will be explored in further analysis of the data, along with other variables. 4 references.

81-1385
Drug and Alcohol Education Programs: A Review of Outcome Studies.
Kinder, B. N.; Pape, N. E.; and Walfish, S.
International Journal of the Addictions 15(7):1035-1054, 1980.

A review of 26 outcome studies on the effectiveness of drug and alcohol education programs, including some that deal with student as well as adult populations, provide data on the efficacy of such programs and on population variables and methods of presentation used in programming. The review analyzed the subject population, educational technique, results, and major limitations of the studies. Data indicated that drug and alcohol education programming has for the most part been ineffective in obtaining the goals of decreasing substance abuse and preventing future abuse. Studies of student populations have obtained contradictory results, but the results established repeatedly indicate that such programs may lead to increased use and sale of drugs and alcohol. Though adult programs seem somewhat more successful, it is not clear which variables (population variables, educational methods) relate to successful outcomes. The majority of the studies suffered from serious methodological flaws. The review recommends that in the future all studies (1) describe characteristics of the subjects and the educational methods employed; (2) use acceptable experimental procedures consistently; (3) use appropriate statistical procedures consistently; (4) include measurements of behavior and attitude as well as knowledge in all outcome studies; and (5) develop psychometrically accurate measures of knowledge, attitude, and behavior. 35 references.

81-1386
Relation of Intensity and Frequency of Student Drug Use to Reasons for Use.
Levy, S. R. and Rasher, S. P.
Journal of School Health 51(5):341-346, May 1981.

A study of 827 undergraduate students from the University of Illinois at Urbana-Champaign, Chicago Circle, and the Medical Center in Chicago assessed the relationship between frequency of drug use and reasons given for drug use. A 124-item, multiple-choice questionnaire was used to elicit information on sociodemographic characteristics, parental use and knowledge of drugs, student health status, and intensity of dosage and frequency of use of 14 drug groups. Results of the analysis indicate that (1) subjects who used alcohol and marijuana for social reasons consume the drugs at moderate to low frequencies; (2) social users of amphetamines, cocaine, psychedelics, and tranquilizers consume relatively larger doses and exhibit more frequent use; and (3) reasons for use can be predicted by frequency, intensity, and sociodemographic variables. More intense and frequent users of amphetamines tend to be social users, while less intense users tend to use the drugs as an experiment. To predict student reasons for use and to differentiate among types of users, a combination of frequency and intensity variables plus sociodemographic characteristics must be considered for future research. 17 references.

81-1387
Breast Self-Examination in the Primary Care Setting.
Miller, S. L., Norcross, W. A.; and Bass, R. A.
Journal of Family Practice 10(5):811-815, May 1980.

A study of 260 women frequenting three primary care centers was designed to investigate rates of breast self-examination (BSE). The sample population was largely white, religiously diverse, highly educated, and young. A three-page questionnaire was completed by participating women over a 2-month period in summer 1978. Questions included 12 multiple-choice items to assess factual risk knowledge and a series of background items to assess subjects' ethnic and demographic characteristics and BSE rates. Statistically significant results indicated that BSE rates were lower for Catholics than for Protestants and Jews and that self-reported rates of BSE were positively associated with the level of education. Older women, who are at higher risk than younger women, had higher self-reported rates than younger women but this finding was not statistically significant. These findings suggest that BSE behavior may be conditioned more by culturally determined attitudes than by rational factors such as a woman's objective risk for, and knowledge of, breast cancer. BSE rates need to be studied for population samples that include adequate representation of minority group women to determine the full extent of cultural influences upon BSE rates. 11 references.

81-1388
Significance of Historical Research in Health Education.
Nolte, A. E.
Health Education 11(6):40-41, November-December 1980.

Ideas in health education that have meaning for health practices, curricula in public schools, curricula in teacher and physician preparation, human behavior, and the many other facets of health education can be traced to actions and time periods of the past. The general importance of historical research in examining events in a meaningful context is discussed, and a list of 12 events is presented which traces the historical development of health education in the United States, beginning in 1872 with the formation of the American Public Health Association and leading up to the establishment of the Bureau of Health Education in Atlanta in 1974 and the National Center for Health Education in San Francisco in 1976. It is suggested that a health history symposium or clearinghouse be established. If health educators concentrate on the historical development of their field, (1) historical data will be generated; (2) techniques of historical research will be shared; (3) evaluation of the present as it relates to the past will be possible; (4) understanding of historical data will occur; and (5) planning for the future based on history will be possible. 7 references.

81-1389
Evaluations of Patient Education Programs: A Meta-Analysis.
Posavac, E. J.
Evaluation and the Health Professions 3(1):47-62, March 1980.

The emphasis on patient education in the treatment of chronic illness has created the need for evaluation methods that go beyond cost-benefit analyses or research studies. One procedure for measuring and comparing the effectiveness of programs using different evaluation methods, called meta-analysis, requires that an "effect size" be calculated for each dependent variable described in an evaluation. Effect size is the difference between the mean of an experimental group and the mean of a comparison group divided by the standard deviation of the comparison group. A literature search yielded 23 evaluations of patient education programs using a randomly selected control group (an experimental design) or a nonequivalent control group (a quasi-experimental design). Meta-analysis procedures combined the findings into an overview of research on the topic. Effect sizes could be calculated or estimated for 104 of the 132 dependent measures in the 23 studies. In the typical study, the average in the group receiving education was the 77th percentile compared to the 50th percentile for the control group. Results revealed that compliance was the dependent variable most strongly affected by the patient education programs; anxiety was less affected than compliance, and mood was least affected. The advantage of meta-analysis procedures stems from the conclusions that may be drawn from diverse studies on a single topic utilizing diverse dependent measures, regardless of sample sizes and statistical significance of individual studies.

81-1390
Anticipatory Guidance in Pediatric Practice.
Reisinger, K. S. and Bires, J. A.
Pediatrics 66(6):889-892, December 1980.

A study of the amount of time pediatricians in private practice spend with patients during well-child visits assessed the proportion of that time pediatricians devote to discussing potential health problems. The study population consisted of a random sample of pediatricians in the Pittsburgh area. Observations of physician-patient interac-

tions were made during 1 day in each of 23 pediatricians' offices, amounting to a total of 305 well-child visits. An average of 10.3 minutes was spent with each patient; anticipatory guidance constituted 8.4 percent of total visit time, a finding which confirms other research on the subject. Pediatricians in group practice or partnerships and those recently trained spent more time with patients and a greater part of their time in anticipatory guidance. The amount of time during the visit spent on potential future problems varied with the age of the patient, the most time being spent with parents of infants less than 5 months old and the least with adolescents. Of particular note was the lack of time spent discussing issues of safety, sex, behavior, and growth. Although nurses and other office personnel were used in a few of the practices to educate parents, their role was minimal. Because pediatricians spend more than 60 percent of their in-office time seeing patients for well-child care, they have an excellent opportunity to motivate parents and patients to adopt healthy lifestyles. This opportunity will be lost, however, unless pediatricians reorient their priorities. 13 references.

81-1391

Primary Prevention Research: A Preliminary Review of Program Outcome Studies.

Schaps, E.; Churgin, S.; Palley, C. S.; Takata, B.; and Cohen, A. Y.

International Journal of the Addictions, 15(5):657-676, 1980.

An evaluative review of 35 drug abuse prevention programs that employed drug-specific outcome measures suggests the effectiveness of such prevention strategies as affective, peer-oriented, and multidimensional approaches. Only 14 studies evaluated purely informational programs. Evaluations were analyzed to ascertain program characteristics, research design, and patterns among findings. The resulting data present evidence that the newer prevention strategies may produce more positive and fewer negative outcomes than did older drug information approaches. Over 70 percent of the programs using the newer strategies produced some positive effects and only 29 percent showed negative effects. In contrast, 46 percent of the informational programs showed positive effects, while 46 percent showed negative effects. These findings must be approached with great caution, since the research was frequently inadequate and since rigor of research was negatively correlated with intensity and duration of program services. 41 references.

81-1392

Smoking Awareness and Practices of Urban Pre-School and First Grade Children.

Shute, R. E.; St. Pierre, R. W.; and Lubell, E. G.

Journal of School Health 51(5):347-351, May 1981.

Ninety preschool children and eighty-two first grade students attending one of five testing sites in Harrisburg and Scranton, Pennsylvania, were studied to determine and describe the level of the children's awareness and practices regarding cigarettes, pipes, and cigars. The preschoolers were predominantly black and lower class, while the first graders were predominantly white and middle class. The children's perceptions were elicited by presenting the children with pictures portraying various tobacco products during individual interviews. Of the seven questions asked for each tobacco product, five could be answered by a yes-or-no response. For the two free-response items, the interviewer recorded the essence of the child's response on the answer sheet. The children's responses indicate that (1) a majority of the children recognized all of the tobacco products; (2) almost all of the children said they knew someone who smoked; (3) 25.5 percent of the children reported having tried cigarettes; (4) boys were almost twice as likely to have tried cigarettes as girls; (5) health hazards and parental disapproval were the typical reasons for disliking cigarettes; (6) a desire to be grownup was the major reason for smoking; (7) having smoked previously and knowing someone who smokes were significantly correlated with the desire to smoke. 8 references.

81-1393

Dietary Counselling and the Behavioral Sciences.

Smiciklas-Wright, H. and Krondl, M. M.

Journal of the Canadian Dietetic Association (Toronto) 40(2):99-103, April 1979.

A presentation at the Annual Convention of the Ontario Dietetic Association in Toronto emphasized that physicians, clients, and dietitians often fail to recognize the complexity of behavioral change, leading to unrealistic expectations of the dietitian's role in effecting change. Nutritional counseling often involves behavior modification, which rests on the premise that behaviors which result in reinforcing consequences are likely to recur in similar situations. Desired changes in dietary practices may not be maintained, therefore, without followup support and counseling. Dietitians should insist upon the resources and support necessary for continued nutritional care. They should also make it clear that lasting dietary changes cannot be achieved in a few sessions. Factors crucial to the success of dietary counseling are the motiva-

sion of patients, their life situation and readiness to participate in a program, and the supportiveness of the patient's social environment. It is important that patients take responsibility for their own changes and avoid reliance on the medical model, which fosters dependency. A behaviorally based, problem-solving approach enables patients to assess eating patterns and evaluate the outcome. Academic preparation and continuing education for nutritionists should supplement training in measurable biological concepts with exposure to psychosocial developmental phenomena. 23 references.

81-1394

Health Care Among Rural Ethnic Minorities: Some Anthropological Observations (Cuidado Medico en los Grupos Etnicos Minoritarios e Indigenos).

Young, J. C.

Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 11 p., (1981).

(English and Spanish).

Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

An overview of current research in the social sciences, particularly anthropology, concerning factors influencing and means of investigating the use of primary health services provides information for health educators working with ethnic minorities and indigenous populations in rural areas. The persistence of a folk or nonscientific orientation toward illness among rural ethnic groups may be as much a consequence of restricted access to the official health care system, due to its cost or distance, as it is a cause of these groups' limited integration into that system. In fact, evidence suggests that the existence of a folk medical belief system is not always a deterrent to the adoption of modern health care practices, but rather is of variable significance depending on the specific behavior in question. In any case, the high incidence of self-diagnosis and self-treatment presents important challenges for health educators in the rural environment. In view of the frequent finding that indigenous healers are often most effective in those areas in which Western medicine is least effective, modern health care providers should attempt to establish an integrated system, keeping in mind the psychotherapeutic benefit that indigenous healers often provide. In both the initial problem-definition stages of health education programs and in outcome evaluation, contemporary anthropological methods for the analysis of clients' decision making offer important research tools. 24 references.

RISK REDUCTION

81-1395

Nutrition Education in the Young. A Statement for Health Professionals. Report of the Ad Hoc Committee on Nutrition Education in the Young of the AHA Nutrition Committee.

Ford, C., et al.

Circulation 62(4):918A-921A, October 1980.

Arteriosclerotic heart disease is the leading cause of death in the United States. Arteriosclerosis is thought to begin in childhood and to progress in adolescence and young adulthood; serious clinical manifestations appear in middle age or later. The American Heart Association promotes modification of adult risk factors in children by means of preventive nutrition education. Early dietary habits may continue lifelong and influence the severity of arteriosclerosis. Four of the risk factors for coronary heart disease--hypercholesterolemia, diabetes, obesity, and hypertriglyceridemia--are diet-related; some also have a genetic, familial basis. Critical to the promotion of good nutritional practices among children are parents, physicians, nurses, other allied health professionals, teachers, school administrators, and school food-service personnel. Nutrition education should be presented to every child on a continuous basis in an integrated sequential manner from kindergarten through high school. Undergraduate programs need to include nutrition education and training. Nutrition messages should be reinforced through the home, community groups, television, and advertising. Cooperative efforts among school systems, departments of health, institutions of higher education, and cooperative extension services are essential. Various facets of the role of the American Heart Association and local heart associations are listed, among them, establishing national priorities in nutrition, influencing legislators, providing consultation, developing educational materials, designing pilot programs, providing teacher inservice training, and establishing cooperative working relationships with other agencies involved in nutrition programs for youth. 34 references.

81-1396

Cigarette Smoking--Four Issues: Health, Political, Social, Economic.

Rocella, E. J.

Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Provider-Policymaker Setting, 30 p., (1981).

Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

The text of a slide show discusses the health issues involved with smoking as well as the related political, social, and economic issues. Tobacco is the nation's fifth most important field crop. Tobacco farmers rely heavily on a Federal Government price support system for their well-being. The Government, in turn, collects an 8-percent tax on each package of cigarettes. Similarly, State and local governments receive revenue from tobacco taxes. The advertising industry spends approximately $800 million per year to promote tobacco use. Liabilities of cigarette smoking in the United States include the estimated 81 million person-days of work lost each year due to cigarette smoking, the billions of dollars spent on medical interventions for smoking-related diseases, and the millions of deaths resulting from tobacco-related diseases. Graphs are included.

81-1397
Strategy (Motivation) for Detection of Early Breast Cancer.
Strax, P.
Cancer 46(4, Suppl.):926-929, August 15, 1980.

Mass screening for breast cancer is the only proven method that can reduce the death rate from the disease. Because minimal or localized breast cancer does not manifest signs or symptoms, mass screening of presumbly asymptomatic or minimally symptomatic women is needed for initial detection. Mammography is needed in addition to palpation since early breast cancer is often not palpable. A successful motivational strategy, particularly for women from low income groups, should emphasize (1) the necessity of the examination; (2) the location and accessibility of screening facilities; and (3) the simple, effective, and safe nature of the examination. Program promotion should be accompanied by such educational efforts as talks to community groups, visits to individuals, magazine articles, educational material provided at the initial examination, and use of the media. Outreach programs may employ health aides to contact members of the community with visual aids, literature, and other material. The Guttman Breast Diagnostic Institute in New York City has developed a simple tandem approach to mass screening: an interview and medical data collection, clinical examination, mammography, and thermography. Breast self-examination is taught to women on a one-to-one basis at the time of participation. 10 references.

81-1398
Accident Prevention and Injury Control.
Wang, V.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Provider-Policymaker Setting, 6 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

A review of statistics on accident prevention and injury control, toxic agent control, and occupational safety and health are provided as background for policymakers concerned with health education. The nature and extent of the problem (including health implications and status and trends) and promotional and preventive measures (including education, technology, legislation, economics, and services) are discussed for each topic.

81P-1399
North Karelia Youth Project.
Puska, P.
University of Kuopio, North Karelia Project, Box 40, 70101 Kuopio 10, Finland
Funding Source: National Health Laboratory, Helsinki, Finland; National Board of Medicine Helsinki, Finland; National Board of Education, Helsinki, Finland.
1978 - 1980.

The North Karelia (Finland) Youth Project, an extension of the North Karelia Cardiovascular Disease Community Control Project, was designed to test the feasibility and effects of a comprehensive school- and community-based program to reduce risk factors associated with cardiovascular diseases among adolescents. The project is sponsored by the University of Kuopio and the Epidemiological Research Unit of the National Public Health Laboratory of Finland. Specific intervention strategies include use of a "Health Passport" to provide the children and their parents with individualized information about their CVD risk, an antismoking program using peer instructors, menu changes in the school lunch program, health instruction for teachers to help them reduce their risk factor levels and provide models for their students, periodic publication of a project magazine that provided the children with feedback on the program, dissemination of health education materials to be used during morning school hours, implementation of a campaign to encourage students to grow vegetables during the summer, implementation of a monitoring program providing the children with ongoing feedback on their progress, promotion of healthy foods through special offers at local shops, home visitation by a nutritionist for children with high serum cholesterol levels, sponsorship of parent meetings, and use of mass media to promote program objectives. Seventh grade students in two schools in the North Karelia Project will receive the intervention program; the other schoolchildren in the North Karelia Project received the general county-wide CVD intervention. The base-line survey in the autumn of

1978 involved three matched pairs of schools and approximately 1,000 children as well as their parents and teachers. Information about school diets was taken as well. The participation rates of children and parents was more than 99 percent. A similar survey will be carried out among the same subjects after the 2-year intervention period.

81P-1400
Swiss National Research Program for the Prevention of Cardiovascular Disease.
Junod, B. and Gutzwiller, F.
Institut Universitaire de Medecine Social et Preventive, Hopital Sandoz, CH-1011 Lausanne, Switzerland
Funding Source: Schweizerischer Nationalfonds zur Foerderung der Wissenschaftlichen Forschung, Bern.
1977 - Continuing.

The Swiss National Research Program for the Prevention of Cardiovascular Disease (NRP 1A) was initiated by the World Health Organization to define strategies that would influence collective and individual behaviors and promote cardiovascular health. Comparable Swiss communities (two French-speaking and two German-speaking communities) were assessed for local channels of communication, and supportive persons were identified in a preliminary study of attitudes toward preventive health programs and potential barriers to implementation. This preparation phase was followed by a survey of the whole population in the intervention communities and a stratified random sample in the control communities. Family history, dietary habits, smoking, physical activity, psychosocial assessment, and knowledge and attitudes were surveyed. Blood pressure, cholesterol levels, blood-sugar levels, height, and weight were measured for all subjects. Preventive activities are proposed to promote health information dissemination, a social support system for high risk persons, school health education, long-term health management systems, recall systems for practicing physicians, smoking cessation programs, relaxation techniques, exercise programs, and dietary intervention. The evaluation will address overall effectiveness of the intervention program, effectiveness of specific educational and other preventive methods, and assessment of costs and benefits of the program. Studies are in progress; preliminary results are published in German and French, and an English publication is proposed.

81P-1401
Vermont Lung Center Public Information and Education Project.
Worden, J. K.
Vermont Lung Association, Inc., 30 Farrell Street, South Burlington, VT 05401
Funding Source: National Heart, Lung, and Blood Inst. (DHHS, NIH), Bethesda, Md.
September 1980 - December 1982.

The Vermont Lung Center Public Information and Education Project for smoking prevention, administered by the Vermont Lung Association, is designed to test two strategies for deterring smoking onset in 10- to 12-year-old children. The first strategy, direct communication through mass media, involves television programs after school and on Saturdays, and posters and placemats at locations where smoking influences may be strong. The second strategy involves indirect communication through youth-oriented community organizations that sponsor workshops and education projects. The impact of both strategies will be assessed by pre- and postprogram surveys of smoking onset behavior, smoking beliefs, and communication with adults and friends about smoking. The Vermont Lung Association will also measure the cost of interventions and will survey the general population for the impact of these two interventions in relation to interventions by other agencies.

SCHOOL HEALTH EDUCATION

81-1402
Are Dental Health Programs in California Schools Adequate?
Alvarez, L.
Journal of the California Dental Association 8(1):53-55, January 1980.

Questionnaires were mailed to 219 teachers and administrators in 30 elementary school districts throughout California to determine oral health education provisions in the State. One hundred and eighty-one questionnaires were returned. Data analysis indicated that (1) 70 percent of the respondents regularly teach health education in their classrooms; (2) most districts do not have a policy requiring that specific topics be taught but leave this matter to the teachers' discretion; (3) brushing and nutrition are the two oral health subjects taught most frequently by teachers; (4) flossing, visiting the dentist, removing plaque, using fluoride, and preventing injuries to the mouth are rarely mentioned; (5) most students never brush their teeth at school and only one teacher reported that students flossed at school; (6) half of the respondents invite dentists to instruct classes, and 32 percent of the teachers received training from dentists; (7) dental screenings are

provided in about half the schools, but are limited to the primary grades; and (9) procedures for referral and follow-up do not exist in most schools. A new relationship must be developed between the dental health profession and the elementary schools in California. 7 references.

81-1403
Meeting the Needs and Challenges for School Health Education in the Americas (Las Demandas y Necesidades de la Educacion Para la Salud Escolar en las Americas).
Bensley, L. B.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, San Juan, Puerto Rico. Provider-Policymaker Setting, 4 p., (1981).
(English and Spanish).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5R0.

Six generic needs as well as various challenges that face schools in implementing and continuing school health education programs include (1) identification of the need for health instruction; (2) establishment of policy statements to set school health education priorities; (3) provision of funds to be allocated for health education programs; (4) determination of political priorities affecting health education allocations; (5) establishment of professional training for health instructors, and (6) provision for systematic planning and evaluation of school health education. All countries in the Americas should examine these needs to ensure quality school health education.

81-1404
Heart Health Education for the Young, It's Important.
Birge, J. E.
Journal of the Medical Association of Georgia 69(7):631-632, July 1980.

In 1973, the Heart Health Education for the Young Committee, a Georgia Affiliate of the American Heart Association, established an educational program on cardiovascular risk factors. A curriculum was developed and introduced in schools for sixth, seventh, and eighth graders. Students were taught the essentials of cardiovascular anatomy and physiology, hypertension, and methods of taking the blood pressure of friends and family members. The program was a success, spreading to 120 of the 156 counties serviced by the Georgia affiliate and to school districts in 29 other States. A followup curriculum on cardiovascular risk factors was developed and disseminated to 60 Georgia counties. In 1980, 28,000 students attending 300 schools in 120 counties will be taught about cardiovascular risk factors, and the committee is collecting data regarding childhood blood pressure. Physicians can provide invaluable aid by promoting the committee's efforts.

81-1405
Consumer Health: Minding Our Own Store.
Corbin, D. E.
Health Education 11(6):22-23, November-December 1980.

Health educators have begun to realize that all major areas of health education are associated with many consumer issues which need to be carefully investigated and addressed. Consumer health teachers need to be aware of the degree to which they participate in making intelligent consumer decisions. They must decide what materials will be used and how they will be used; convey accurate messages in understandable language; and assume responsibility for course objectives, methodologies, and resources. Overuse of vague health-related words such as humanistic, holistic, and wellness should be avoided, and standards should be established for health education definitions. Health educators need to point out the limitations of consumer choices and self-control in both sickness and health care and emphasize conflicts of interest and biases in health materials so that students and consumers can make intelligent decisions based upon critical evaluation. Textbooks are limited and the modern health educator should draw from a wide variety of other sources. No single book, teacher, or course can adequately cover a field so diverse and complicated as health education. 13 references.

81-1406
Avoiding the Lure of the Snake-Oil Salesman: An Argument for Individualized Instruction.
Davis, M.
Health Education 12(2):21-22, March-April 1981.

School health educators must begin to develop programs based on assessment of individual needs and tailored to the learning style of the individual student. School health educators would be wise to follow patient educators in their formulation of individualized education schemes. Health inventories provide excellent data for the development of individualized programs, and research into high-risk characteristics allows specific target populations to be defined accurately. Identification procedures can be initiated as early as the second and third grades. Educational assessments, similar to the general health assessments cur-

rently made by school nurses, can provide the basis for individualized health education prescriptions. 5 references.

81-1407
Urban Setting School Health (Ambiente Urbano la Salud Escolar).
deWit Greene, A. G.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 12 p., June 2, 1981.
(Spanish and English).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

School health education activities are reviewed in light of their importance to the health status of nations. School health programming promotes a safe and healthful school environment, provides health services for the children and adult school personnel, and provides formal health education. The mixture of agrarian and urban health problems in the developing countries of the Americas and the migration from rural to urban areas have created unique problems for these countries. To address these problems, teachers must receive special professional preparation during college training including inservice workshops. Preventive activities should be promoted in health education textbooks. Finally, health content areas that should receive priority in programming include growth and development; accidents and injuries; communicable and parasitic diseases; cardiovascular diseases; degenerative diseases; nutrition; drug abuse; behavioral diseases; and conception, pregnancy, and birth.

81-1408
Rural School Health Education: Historical Importance--U.S. Focused.
Doran, P. C.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Rural Setting, 6 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

Although health was established as the primary objective of education in 1918 by the Commission on the Reorganization of Secondary Education, the last 60 years have witnessed only limited efforts to promote school health education, particularly in rural areas of the United States. Findings by the School Health Education Study of 1961-64, the President's Committee on Health Education of 1973, and the National Education Association's special bicentennial committee of 1975 attested to both the inadequacy of current school health education policies and the importance of school health education. These findings gave rise to the development of the Center for Health Promotion and Education and the National Center for Health Education (NCHE) as well as program initiatives from numerous other health and health education associations. The NCHE's School Health Education Project, which was initiated to design a comprehensive curriculum for kindergarten through seventh grade, and the Comprehensive School-Community Health Education Project of the National Parent-Teacher Association have identified alcohol use, nutrition, and sexuality as priority areas for school health education. In applying these findings to rural areas, planners must take into account factors related to the geographical remoteness, economics, social networks, community resources, and lifestyles that are unique to the rural setting.

81-1409
A Project to Improve Competencies in Basic Health Knowledge.
Fast, C. G.
Health Education 11(6):42-43, November-December 1980.

College students enrolled in a school health education course were administered the Fast-Tyson Health Knowledge Test to diagnose their strengths and weaknesses. They were then given a personal data sheet with information regarding their individual weak areas and instructed to do independent study and to develop a factsheet prior to retesting. The results were assessed and used to indicate remaining weak areas from which to select a major instructional project for the course. Areas requiring additional work in class were substance abuse, nutrition and diet, disease control, and sex and family life. Prior to independent study, students knew more about safety and first aid than the other health areas. Retesting revealed that independent study can lead to a decided improvement in basic health knowledge to support classroom health instruction.

81-1410
Should Health Behavior Change Be the Objective of Health Education?
Heit, P., Meeks, L. B.; and Hochbaum, G. M.
Journal of School Health 51(5):379-380, May 1981.

While some health educators feel that behavior change is the key outcome of school health education interventions, others feel that it is more important to endow students with lasting knowledge, attitudes, values, and determination that will enable them to make prudent health-related decisions. Arguments for both sides are briefly discussed.

81-1411
Death Education: Do We Need It?
Henney, M. and Barnhart, R. S.
Psychological Reports 46(3)Part 1:996-998, June 1980.

Findings are presented from a survey on death education in the elementary schools conducted among 100 elementary teachers in northwestern Iowa. Analysis indicates that death and dying is formally taught by less that 1 percent of teachers, although many teachers expressed willingness to consider the topic. Findings imply that teachers felt that people closest to a child, namely a parent or classroom teacher, should be responsible for teaching about death. The church is recognized as a good source of instruction as well, and was in all cases named in conjunction with the parent. To teach a unit about death effectively, teachers need preparation either at the pre- or inservice level to provide them with knowledge of content, activities, and methods for helping children understand death. 5 references.

81-1412
Evaluation of a Comprehensive Cardiovascular Curriculum.
Holcomb, J. D.; Carbonari, J.; Weinberg, A.; and Nelson, J.
Journal of School Health 51(5):330-335, May 1981.

A study of 867 ninth graders enrolled in health classes in a large suburban school district in Houston, Texas, assessed the efficacy of the Cardiovascular Curriculum Education Project. The curriculum consists of a series of nine independent, self-instructional units focusing on the circulatory system and heart, cardiovascular diseases, cardiovascular disease risk factors, and warning signs for heart attack and stroke victims. The curriculum was augmented with classroom activities, audiovisual resources, homework assignments, and achievement tests to form a 2-week, 10-lesson program. Teachers were provided with lesson plans that emphasized multimedia presentations and student participation. The teachers also attended a 3-hour inservice training program. A 30-item posttest was used to assess knowledge in the 550-subject control group and the 317-subject experimental group, and teacher acceptance of the curriculum was assessed with a questionnaire. Results of the evaluations indicate that: (1) the experimental students demonstrated significantly more knowledge than control students in all areas associated with cardiovascular disease; (2) experimental students showed more concern for and confidence in their ability to affect their cardiovascular heath; and (3) teachers expressed strong acceptance of the curriculum. 19 references.

81-1413
Results of the Health Education Survey of Public Schools in the Houston-Galveston Area.
Houston-Galveston Area Council Health Systems Agency, Houston, Tex.
Houston, Tex., the Agency, 19 p., 1980.
Available from: NTIS; Order No. HRP-0902432.

A health education survey, administered to 830 public schools in a 13-county health service area in Texas covered health curricula, amount of time dedicated to teaching health education, designated health educators, and necessary improvements for development of health curricula in their schools. The 230 responses were computer analyzed by Health Systems Agency's Data Section; computer analysis consisted of simple frequency and cross-tabulation by grade level. A significantly high number of school officials across grade levels cited the need for health education improvements, increases in health education budgets, and technical assistance in teaching health education courses. Responses from high schools that are required to teach one semester of health education most frequently indicated curricula that included reproduction, abortion, venereal disease, and contraception. Over 80 percent of all school officials claimed that their schools included material on nutrition, exercise theory, immunization, accident prevention, dental care, alcohol use and abuse, drug use and abuse, personal hygiene, emergency procedures, first aid, and the effects of smoking. Only 32 percent of the schools had a designated health education teacher. A copy of the survey instrument is appended.

81-1414
How to Plan Inservice Health Education for Elementary Classroom Teachers.
Kolacki, E. C.
Health Education 12(2):32-34, March-April 1981.

Guidelines have been developed for facilitating inservice health education courses for elementary teachers. The teacher must be prepared to influence the pupil's identity, attitudes, values, and habits. An effective inservice training course should include increasing knowledge of health

topics and skills that encourage decision making by students, cultivating the ability to discriminate between fact and fiction, increasing the understanding of stress affecting schoolchildren, and increasing the ability to evaluate self-performance. Other areas that should be addressed include schedules for inservice courses, location of the course, appointment of an inservice director, delineation of the responsibilities of the director, selection of speakers and consultants, selection of representative participants, institution of course credit and salary credit provisions for participants, and outlines of content and activities.

81-1415
Death Education: An Integral Part of School Health Education.
Lang, D.
Health Education 12(2):38-39, March-April 1981.

A death and dying curriculum that can be incorporated into a health education course has been developed. The 14-session unit and a 10-item, multiple-choice attitude and information inventory have been tested with students attending Turkey Valley Community Schools in Jackson Junction, Iowa. After an introductory session, the course goes on to address the vocabulary of death, the Protestant-Catholic view of death, American perceptions of death, the five stages of death, life insurance, military views of death, medical examiners' views of death, perceptions of people who have been revived after dying, funeral homes, euthanasia, and children's perceptions of death. Educational aids and methods used include drawings, lectures from ministers, a class collage, films, filmstrips, and fantasy exercises. 5 references.

81-1416
Nutrition Education for Grades 7-12: The Perspective of Pennsylvania Teachers and Administrators.
Marr, T.; Shannon, B.; and Spanier, G. B.
Journal of Nutrition Education 12(3):148-152, July-September 1980.

A survey of 2,706 Pennsylvania junior and senior high school administrators and teachers was conducted to determine their opinions on nutrition education for 7th through 12th grade students. Of the 1,366 responses, 96 percent were teachers and 4 percent were administrators. Only 22 percent of the respondents had taken a college-level course in nutrition; most of the teachers taught home economics, health and physical education, or life sciences. Teachers in these three subject areas expressed the greatest interest in teaching nutrition. However, there was strong agreement among all respondents that nutrition should be taught to 7th through 12th grade students. Both teachers and administrators favored integrating nutrition education into existing courses rather than teaching it as a separate course. Courses considered most appropriate for this were health and home economics and, to a lesser extent, biology and physical education. Teaching nutrition as a minicourse at several points during 7th through 12th grade also received support. A comprehensive approach to nutrition education would teach fundamental health concepts dealing with diet and nutrition in seventh and eighth grade health units, complementary units in later home economics and biology courses, and units on nutrition principles in sports, pregnancy, weight reduction, and management of food costs taught as separate minicourses for upper grades. 9 references.

81-1417
Family Functioning and Substance Abuse: Theory, Research, Revision of Theory and Research, and a Community School Based Adolescent Family Health Education Project.
Needle, R.
Paper presented at the Inter-American Symposium on Health Education, May 31 - June 4, 1981, San Juan, Puerto Rico. Urban Setting, 29 p., (1981).
Available from: International Union for Health Education, North American Regional Office, in care of CAES, P.O. Box 2305, Station D, Ottawa, Ontario, Canada K1P 5K0.

A longitudinal prospective study involving 294 sixth, 292 seventh, 282 eighth, and 303 ninth grade Minnesota public school students and their families will be designed to determine the influence of peers and parents on substance use among adolescents. The overall goal of the study is to develop a variety of preventive intervention strategies to enhance the abilities of young adolescents and their families to adopt positive behaviors regarding alcohol and tobacco use. Intervention strategies to be assessed include peer-led groups, teacher-led groups, and participation of parents in promotion of positive attitudes and behaviors. The project will be undertaken in three phases: (1) preprogram evaluation of adolescents and their families, instruction of peer leaders and teachers, and preparation of a curriculum and associated educational materials; (2) implementation of the educational interventions during bimonthly meetings with selected groups of students and separate meetings with their families; and (3) administration of posttests to the population and analysis of data. The study will be implemented so that both enabling and reinforcing factors can be identified. Specific behavioral objectives, by which the project will be evaluated, have been outlined.

81-1418
Implications for Curriculum.
Pate, R. and Corbin, C.
Journal of Physical Education and Recreation 52(1):36-38, January 1981.

The newly developed American Association for Health, Physical Education, Recreation, and Dance (AAHPERD) Health Related Physical Fitness Test (HRPFT) is reorientating physical education curricula. Several lists of guidelines are given for administration of the HRPFT and its incorporation into overall school health education goals. The Physical Fitness Taxonomy (a model permitting priorities of objectives) is used to classify physical education objectives into six levels: (1) physical fitness vocabulary; (2) exercising; (3) achieving physical fitness; (4) establishing regular exercise patterns; (5) physical fitness evaluation; and (6) physical fitness problem solving. The lower order objectives are teacher oriented, while higher order objectives are student oriented. With the HRPFT, students will have a basis for determining their own health and fitness needs. The test may also help learners meet higher order fitness objectives. If physical education programs are to be effective, learners must establish their own exercise patterns; they must be able to test themselves and interpret their own test results, and, through retesting, see themselves improve. Most importantly they must be able to solve their own fitness problems and to plan their own exercise programs. 4 references.

81-1419
Exercise Prescription.
Pollock, M. L. and Blair, S. N.
Journal of Physical Education and Recreation 52(1):30-35, 81, January 1981.

A discussion is presented of practical guidelines concerning the right amount of exercise to develop and maintain health-related fitness as described in the new "AAHPERD (American Association for Health, Physical Education, Recreation, and Dance) Health-Related Physical Fitness Test Manual." The basis for fitness programs is a scientifically designed exercise prescription that includes cardiorespiratory function, body composition, abdominal muscular strength, and low back-posterior thigh muscle and joint flexibility. It is recommended that physical fitness activities be integrated into schools as early as possible to offset potential health problems related to lack of physical activity, promote optimal development and fitness for each individual, and foster a positive attitude toward physical activity and long-term involvement in exercise. Students should be instructed in the importance of regular exercise, taught concepts of fitness development and maintenance, and encouraged to help plan and take responsibility for their own fitness improvement and maintenance. Physiological adjustments to increased fitness vary with the frequency, intensity, and duration of regular physical activity. Improvements in fitness levels vary according to the intensity of the workouts, initial level of fitness, and individual differences. The manual also provides exercise prescription guidelines to assist teachers and students in developing desired objectives and selecting the appropriate amount of exercise. Exercise prescription is based on frequency, intensity, and duration of training, and mode or type of activity, as well as initial level of fitness. Six suggested behavioral techniques are presented to help teachers and coaches assume leadership in structuring exercise prescriptions and motivating participants to adhere to them. 42 references.

81-1420
Making Tobacco Education Relevant to the School-Age Child.
Seffrin, J. R.
Health Education 12(2):11-15, March-April 1981

Decisions to smoke or not to smoke are made by people very early in life, and the role of the school health educator during primary and middle school years is of critical importance. American cultural values place emphasis on personal rights and pluralistic values, demanding that the educator objectively address both the physiological and psychological factors associated with cigarette smoking. The students' right to choose and their responsibility for the consequences of their choices should be stressed. Areas that are particularly relevant to student decisions include cigarette smoking as the nation's leading preventable health problem, the immediately harmful effects of smoking, the misguided notion of safe smoking, harm inflicted upon others due to "indirect" smoking, dependency problems associated with addiction to tobacco, and the comparative advantages of not smoking over smoking. Sociopolitical issues that should be addressed include the optimum Federal policy toward tobacco, payment of smokers' health care, and rights of smokers and nonsmokers. Numerous references.

81-1421
A School Health Education Program.
Shenker, B. M.
Connecticut Medicine 44(8):519-520, August 1980.

Early in the 1970's, a group of educators in Connecticut developed a comprehensive health education curriculum and teaching guide for grades K-12, which has proved to

be highly effective. The information is presented to the children by the classroom teacher rather than a health educator. The role of health educators has been to coordinate the program, make available to teachers all resources (books, pamphlets, videotapes, special demonstrations, and guest speakers), meet with individual teachers to discuss problems of interpretation and presentation, and advise teachers on the currency of educational material and sources of newer and better materials. The subject matter is adjusted to the school grade level and is uniform throughout the entire school system. An advisory group of administrators, teachers, medical personnel, and students are responsible for program evaluation. A major problem encountered in implementing the curriculum has been elimination of the health educators' positions due to budget cuts. To assure the continued stimulus and expertise provided by the health educators, approval has recently been obtained for city funding augmented through Federal or State grants.

81P-1422
"Alternatives" Drug and Alcohol Prevention Program.
Blangiardo, J.
Community School District 22, 2525 Haring Street, Brooklyn, NY 11235
Funding Source: New York State Office of Alcoholism and Substance Abuse, Albany. Div. of Substance Abuse Services.
Continuing.

"Alternatives," an alcohol and drug abuse prevention program serving New York City's School District 22, was founded to assist the community in the prevention of drug and alcohol abuse particularly among elementary and high school students, and to provide school personnel with training necessary to mount a prevention program. The program for the 1981-82 school year will provide assistance and training to community organization personnel, educational interventions for students, and inservice training for school personnel. The entire student population of the district, which includes 24,500 students as well as their parents and teachers and other community members will constitute the target audience. The 500 merchants in the community who are licensed to sell alcoholic beverages will be targeted for a special outreach effort. Program staff will coordinate their activities with a number of organizations, but the Community Task Force Against the Sale of Alcohol, a 30-member committee of parents, teachers, community leaders, and police, will constitute the chief contact point with the community. Record-keeping systems will be developed to document training and assistance provided to local organizations and individuals, changes in students behavior, knowledge, and understanding of emotional and psychological growth during adolescence. Pre- and postprogram tests will be administered to representative samples of students participating in the program and nonparticipating students to provide controlled experimental conditions. Monthly reports will be submitted on the progress of program interventions. Verifiable objectives have been developed for evaluating change in the behavior, knowledge, and attitudes of the student target group.

81P-1423
St. Olaf College Alcohol-Drug Education and Assistance Program.
Roberts, B. B.
St. Olaf College, Northfield, MN 55057
1975 - Continuing.

The St. Olaf College Alcohol-Drug Education and Assistance Program is one of 62 programs, including 50 at universities representing each State and at 12 small colleges, that are aimed at reducing the incidence and prevalence of alcohol- and drug-related problems among college students. Like the other programs that emerged from the "50 plus 12 Alcohol Conference for Colleges and Universities" held at the University of Notre Dame in 1975, the program increases student knowledge about alcohol and drugs, teaches decision making, encourages persons who know substance abusers to confront them, increases discussion and awareness among students and staff about problems related to drug and alcohol use, provides ready access to sources of assistance on campus and in the nearby community, reaches out to abusers, supports campus and local organizations who provide self-help to substance abusers, and serves as a campus catalyst for development of chemical-free events by existing clubs and organizations. Program components include training and education programs for persons who have responsibility for assisting or supervising others, a computer program that assesses substance use behavior and provides referrals when necessary, education programs developed by formal or informal campus groups, articles published in the student newspaper, classes on chemical abuse, educational workshops, liaisons with local businesses that sell alcohol, and liaisons with regional chemical dependency center personnel, media messages and education programs for the entire community, and a network of professionals and lay volunteers who assist abusers. A steering committee of 8 to 15 students and 1 to 2 administrators oversees the activities of the program. The target audience consists of the 3,000 students and 200 faculty members at the college. Evaluation efforts have been inconclusive. Each year the student government and the administration each contribute $900 for operation of the program.

SELF-CARE

81-1424
NCI Urges Expansion of Successful Study on RNs Teaching Breast Self-Examination.
American Journal of Nursing 81(5):924, May 1981.

In a major effort to promote monthly breast self-examination (BSE), the National Cancer Institute (NCI) will urge all hospitals to replicate a successful BSE teaching project conducted at 19 hospitals in Utah, Idaho, and Wyoming. The 12-month pilot study assessed the effectiveness of a nurse-instruction plan employing informational materials that were developed and distributed by NCI. The study involved 1,130 nurses who were given inservice BSE instruction and demonstration before teaching 6,680 women in BSE techniques. Program effectiveness was evaluated via phone interviews with 1,620 women hospitalized during the test period. Fifty percent of the women who had received the program reported that they were making monthly self-examinations. By contrast, only 30 percent of the women in a control group that had not been taught reported regular self-examinations. This study and others proved the effectiveness of the program and the potential for integrating BSE into nursing service schedules without imposing a major burden on hospital staff.

81-1425
Mutual-Help Groups: Enhancing the Coping Ability of Oncology Clients.
Adams, J.
Cancer Nursing 2(2):95-98, April 1979.

Well-established mutual-help groups organized outside the sphere of institutions or professional authority have been repeatedly cited for their valuable contribution to the rehabilitation of cancer patients. Given a conducive social climate, rapid technological advances, increasing numbers of chronically ill, and the influence of stigmatizing traits, mutual-help organizations have become an established social phenomenon. Bewilderment and confusion regarding the health care delivery system and the perceived lack of professional services for perceived needs have been an impetus in the formation of some groups. Typically, such groups serve four functions: exchanging special information and coping techniques, encouraging maintenance of a regimen, normalizing behavior, and educating health professionals and the public. The primary function of modeling underlies all these areas and is the crux of their effectiveness. Trained volunteers provide a representation of successful coping to cancer patients. Health care providers should become acquainted with mutual-help resources in the community. Professionals may become usefully involved in these groups by conducting research in such areas as change in coping behavior of members compared to nonmembers, the types of individuals who elect to join mutual-help groups, and the function of modeling behavior for the one helping and the one being helped. Current coexistence between these groups and professional health care providers could evolve into mutual-help relationships to improve the services available to individuals and families affected by cancer. 18 references.

81-1426
Self-Care and Self-Medication.
Fry, J.
Journal of Family Practice 12(1):151-152, January 1981.

Self-care is a neglected, but important, level of health care. Family physicians should teach patients about their responsibilities in health maintenance, disease prevention, self-care, and self-medication. Sixty percent of people in the United States and the United Kingdom take medication daily. Of this 60 percent, 27 percent take prescribed medicines and 33 percent take self-prescribed, over-the-counter drugs. The most popular self-prescribed drugs among adults are analgesics, vitamins, cough medicines, skin preparations, and drugs for gastrointestinal disorders. There are wide variations in drug use levels across national boundaries, indicating variations in local and national self-medication customs. Physicians must be prepared to instruct patients in self-medication and in the use of medication algorithms. 2 references.

81-1427
Indisposed to Medicine: The Women's Self-Help Movement.
Gapen, P.
New Physician 29(5):20-24, May 1980.

A review of the development and extent of the women's self-help movement in health promotion and education provides insight into the advances made by women in this area and controversies that have arisen as a result. Emerging from the feminist self-help groups of the late 1960's, the movement began to expand rapidly in 1969 when the Boston Women's Health Book Collective produced the first women's self-help book of the century. Other feminist groups lobbied for legislative changes and pressured Federal agencies to make policy changes. The backbone of the movement, however, was 50 feminist health centers distributed nationwide that educated women in self-care and health consumerism and provided them with routine

medical care. Physicians often view the centers, particularly abortion services, as both an economic and an intellectual threat. In response, feminists claim that flaws in the means by which physicians treat women are a result of the medical profession's continuing preoccupation with males, a penchant for devising aggressive treatments, and a relationship with big business that tends to lead to the development of drugs to solve medical problems.

81-1428
Caring for Ourselves: An Alternative Structure for Health Care. Report on the Vancouver Women's Health Collective.
Kleiber, N. and Light, L.
Vancouver, B.C., Canada, School of Nursing, University of British Columbia, 184 p., April 1978.

The Vancouver Women's Health Collective is a nonhierarchical feminist organization providing health education and preventive care to women. In March 1973, the collective initiated free services using grants from the Federal Government and local agencies and, eventually, from the Provincial Government. Three years of descriptive research on the collective, which emphasizes preventive health care, education, and equality among participants, were undertaken to document the group's development and operation and evaluate its efficacy. The application of the descriptive methodology provides insights into: the impact of the research on the collective, the structure of the collective, the political consciousness of collective members, self-help groups at the collective, lay workers and health care delivery, body politics, health collective members, clients of collective services, membership processes in the collective, the effects of funding on the collective and its members, the general organization of the collective, health information telephone and drop-in services, abortion counseling services, diaphragm-fitting services, health education groups, health information resources, community education services, the Vancouver Women's Self-Help Clinic, the impact of the clinic on women clients, and physicians at the clinic.

SEX EDUCATION

81-1429
Sexual Experience, Birth Control Usage, and Sex Education of Unmarried Canadian University Students: Changes Between 1968 and 1978.
Barrett, F. M.
Archives of Sexual Behavior 9(5):367-390, October 1980.

A questionnaire survey of 1,200, 1,300, 2,950, and 2,985 unmarried students attending the University of Toronto in 1968, 1971, 1974, and 1978, respectively, was conducted to determine changes in sexual experiences at the university. Questionnaires were mailed to a sequential sample of full-time graduate and undergraduate students each year. Response rates to the 40-item questionnaire were 44 percent, 59 percent, 52 percent, and 53 percent in 1968, 1971, 1974, and 1978, respectively. A comparison with university registration statistics indicated that respondents to the first three surveys were representative of the total population in age, sex ratio, and distribution among colleges. Results of the surveys indicated that the percentage of females who had had sexual intercourse increased from 32 percent in 1968 to 58 percent in 1978, and the percentage of males who had had sexual intercourse increased from 40 percent to 62 percent. There were no significant changes between 1974 and 1978 for either sex, nor were there sex differences in coital experiences in either year. Females who had had sexual intercourse were more likely to have had intercourse in the 3 months preceding both the 1974 and 1978 surveys, but otherwise there were no sex differences in coital frequency, lifetime number of partners, or age at first intercourse. Males were more likely than females to report postpubertal homosexual contacts. Contraceptive risk-taking was high at first intercourse and among those having infrequent coitus. Risk-taking was lower in 1978 than in 1968, largely due to increased use of the pill. 23 references.

81-1430
Student-Parent Rapport and Parent Involvement in Sex, Birth Control, and Venereal Disease Education.
Bennett, S. M. and Dickinson, W. B.
Journal of Sex Research 16(2):114-130, May 1980.

A questionnaire designed to elicit students' feelings about sex education instruction and topics was administered to 102 women and 97 men, 18 to 19 years old, attending the Commonwealth Campus of the Pennsylvania State University. The questionnaire included items concerning preferred and actual sources of sex education; student rapport with parents; religious affiliation; and general knowledge about sex, birth control, and venereal disease. Responses indicated that the students favored parental responsibility for sex education and that rapport is associated with parent-child discussions of sex. Both rapport and parental involvement in sex education were positively related to satisfaction with mode of sex education, especially among females. Neither rapport nor parental involvement in sex education had a meaningful impact on practical knowledge of sex in the areas assessed. Though there seemed to be widespread support among students

for sex education by parents, frank discussion of sex between parent and child was acknowledged to be infrequent. These findings must be qualified due to the methodological limitations of the study, which include use of retrospective data and the absence of information on the quality of parent-child communication. Numerous references.

81-1431
Sex Education: Sweden's Experiences--Success and Failure.
Bergstrom-Walan, M. -B.
British Journal of Sexual Medicine (London) 4(1):18-19, January 1977.

In order to revise the 1956 sex education guidelines, the Swedish Government asked a small group of experts to evaluate the progress and efficiency of sex education. The 800-page final report revealed that more than 90 percent of the adult Swedish population was in favor of sex education in schools, most felt that premarital intercourse was acceptable if the partners were in love, 90 percent of the married persons advocated marital faithfulness, 80 percent of the high school pupils favored more information and discussion concerning sexual norms and wanted the sex educator to be a visiting expert, most pupils consulted printed literature to obtain sexual information, only 20 percent of the teachers were interested in teaching sex education courses, and over 70 percent of the teachers reported insufficient training in sex education. As a result of these findings, the committee recommended that students should (1) learn anatomy, physiology, psychology, ethics, and sociology; (2) acquire an objective and comprehensive orientation about various norms and attitudes of importance for sexual life; (3) develop the ability to perceive sexuality as an integrated part of human life; and (4) acquire increased consciousness to enable them to make informed personal decisions. 2 references.

81-1432
Sexuality and Disability: A Selected Annotated Bibliography.
Cornelius, D.; Makas, E.; and Chipouras, S.
Rev. ed. Washington, D.C., Regional Rehabilitation Research Institute on Attitudinal, Legal and Leisure Barriers, George Washington University, 78 p., July 1979.

Annotated citations of 412 articles, books, and pamphlets on sexuality and disability are provided for use by health educators, human development specialists, and others interested in the field. Literature cited includes material on arthritis; heart disease; diabetes; mental retardation; spinal cord injury; spina bifida; paraplegia; quadriplegia; sexuality for the elderly; blindness; deafness; cerebral palsy; mastectomy; renal disease; sex education, counseling, and therapy for the disabled; general sex education and therapy; physiological information; adolescence and sexuality; female sexual functioning; socialization; sexual rights; sexual techniques: institutionalization; professional training; theory and instrumentation; and families and spouses.

81-1433
Ending the Constant Crisis in Health Education.
Corry, J. M. and Gray, B. J.
Health Education 8(4):26-28, July-August 1977.

In 1977, health educators faced the latest of a series of crises among youth spanning the 1960's and 1970's: pregnancy among adolescents. As the identified causes are similar to those of previous nationwide problems, a health education approach that emphasizes general mental health skills would be useful and relevant in all health-related crises, with the ultimate goal of preventing future ones. One million 15- to 19-year-old girls become pregnant each year, and 33,000 pregnancies occur before the age of 15. These teenage pregnancies are due primarily to lack of consistent use of good contraceptives. Research has shown that adolescents know about contraceptives, espouse positive attitudes toward contraceptive use, have access to contraceptives, but do not use them. For adolescents, failure to accept their sexuality, incomplete development of abstract cognitive abilities, and fixation at lower moral reasoning levels (as defined by Kohlberg) have been identified as factors that may combine to confuse young people and produce unpredictable decision-making behavior with regard to contraceptive use. A program of primary prevention through mental health education coupled with superior health services would be the best approach to heading off future crises such as this one. Characteristics of such a program would include (1) full and healthy consideration of controversial problems facing youth--in this case, sexual self-acceptance; (2) a combination of affective and cognitive learning, and a humanistic, whole person orientation; (3) teaching methods and a classroom atmosphere that encourage development of mental health skills, such as effective communication and responsible decision making; (4) methods for improving formal operational thinking and ability to resolve moral dilemmas maturely, using some of the values clarification techniques; and (5) emphasis on comprehensive skill building over a long period of time, ideally from kindergarten through 12th grade. Only by dealing with the whole person can health educators hope to make an impact on the current crisis of adolescent premarital pregnancy and all future crises. 11 references.

81-1434
Are You an Askable Physician?
Gordon, S.
Clinical Proceedings - Children's Hospital National Medical Center 36(6):345-349, November-December 1980.

Because of their intensive training and positions of respect, physicians are ideally situated to assume the role of sex educators for their adolescent patients. Despite the prevalence of physician-teenager interaction, teens report that they receive little if any information from their doctors. For counseling and knowledge, they must turn to family planning centers, free clinics, hotlines, the media, and friends (parents are listed as reliable sources by no more than 20 percent of young people). Physicians should not think that adequate sex education already exists in the schools, or that young people know all about sex from the media, peers, and their own experiences. To meet the special needs of adolescent patients, physicians must be willing to surmount the obstacles presented by professional ethics, personal convictions, and legal ramifications. Besides crisis-oriented areas such as venereal disease and abortion, there are innumerable issues on which physicians can dispense useful information by discussion and appropriate literature. A list of sexual concerns and information needs most frequently sought by teenagers is provided, along with general principles for communicating with young people about sexuality. 1 reference.

81-1435
Four Statements on Values and Sex Education.
Hennessy, T. C.
Personnel and Guidance Journal 58(9):598-601, May 1980.

Four statements on sex education which emphasize values and the bearers of values are discussed: (1) future sex education programming should de-emphasize the importance of the physiological aspect of human sexuality; (2) the values approach to sex education should be emphasized; (3) parental and religious influences should be recognized; and (4) counselor involvement should increase.

81-1436
Contraception-Abortion Lifeline.
Richardson, G. E.
Health Education 12(2):37, March-April 1981.

The contraception-abortion lifeline technique was developed as a values clarification exercise for sex education courses. The method involves drawing a "lifeline" on the board with key physiological development points labeled. Students are invited to volunteer their beliefs concerning the point along the line at which life begins. This process can be slowly developed into a discussion of contraception and abortion. The point at which the various methods of contraception or abortion intervene may be marked. Students can be questioned on the intellectual, spiritual, emotional, and social acceptability of intervening at each point marked. The ensuing values discussion should concentrate on the right to intervene before and after the point designated by each student as the beginning of life.

81P-1437
Communicating About Sexuality: Parent and Child.
Wuerscher, A.
Family Planning Program, University of Connecticut Health Center, L-4071, Farmington, CT 06032
Funding Source: Dept. of Health and Human Services, Washington, D.C.
1974 - Continuing.

The Statewide Family Planning Training Program of the University of Connecticut's Health Center offers a course called "Communicating About Sexuality: Parent and Child," designed to train staff such as community leaders, teachers, and workers in health and social service agencies; counsel parents in their role as sex educators; and teach a sex education program for parents enabling them to clarify their own sexual values and communicate more effectively with their children. Fifteen 3-hour sessions focus on the individual's feelings toward sexuality, personal sexuality assessment, the sexual and reproductive system, values clarification and decision making, communication, sexual attitudes and behaviors, sexuality and disability, educational resources, the teaching and learning environment, and skills development and application. Course assessment and skill acquisition measurements are experimental and include tests to assess basic information, methodology, and materials related to communicating about sexuality; self-assessment records including attitudes and values, checklists, personal journal entries, and evaluation of classroom and taped activities; written and oral reports on communicating about sexuality; and behavior checklists to evaluate participant performance in classroom activities and on tape as observed by the instructor or outside evaluator. The instructor's manual provides an overview, goals and instructional objectives, teaching plans, and references for each of the 15 sessions. Other courses offered by the Statewide Family Planning Training Program include instruction on counseling skills, medical interviewing, family planning, human sexuality, and reproductive and family health care.

81P-1438
Growing Up Male.
Foster, L.
Planned Parenthood of Fresno, 633 North Van Ness Avenue, Fresno, CA 93728
Funding Source: Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
February 1980 - Continuing.

"Growing Up Male" was developed by Planned Parenthood as one of two parent-child workshops encouraging sex education to parents and children together to promote communication for further family discussion. "Young and Female" and "Growing Up Male" originally separated the sexes in mother-daughter and father-son workshops, but current programs are for parents with their pre-adolescent children. "Growing Up Male" presents films, personality qualities exercises, and discussions with parents and with peers alone. Fathers and sons provide self-evaluation forms measuring their changes in knowledge, attitudes, or practice resulting from the program. Materials for participants include a brochure describing Planned Parenthood's medical and educational services, self-evaluation sheets, a sheet entitled "Suggestions for Approaching Sex Education," a booklet entitled "Sex Education at Home," and 3 X 5 cards for requesting topics during discussions. Films include "Human Growth and Development III" and "Am I Normal?" "How to Live with Your Parents and Survive" is a slide-tape on value conflicts. Responses from program participants have been positive. Parents say that they have become more willing to discuss sex with their children and feel more comfortable about discussing sex. Many parents admit an incomplete knowledge of sexual development and appreciate the chance to acquire information. Three out of four youngsters have indicated that they would attend other similar programs.

81P-1439
Young and Female.
Foster, L.
Planned Parenthood of Fresno, 633 North Van Ness Avenue, Fresno, CA 93728
Funding Source: Bureau of Community Health Services (DHHS, HSA), Rockville, Md.
October 1978 - Continuing.

"Young and Female" was developed by Planned Parenthood as one of two parent-child workshops encouraging sex education for parents and children together as a first step toward establishing lines of communication for further family discussion. "Young and Female" and "Growing Up Male" originally separated the sexes but current programs are for parents with their pre-adolescent children. "Young and Female" presents films, a body diagram to familiarize participants with male and female reproductive anatomy, and discussions of parent-child relationships. Materials for participants include a brochure describing Planned Parenthood medical and educational services, a self-evaluation sheet, a sheet entitled "Suggestions for Approaching Sex Education," a booklet entitled "Sex Education at Home," and 3 X 5 cards for requesting topics during the discussions. Films and audiovisuals cover human growth and development, value conflicts between parents and teens, and self-discovery. Responses from program participants have been positive. Parents say that they have become more willing to discuss sex with their children and feel more comfortable discussing sex. Many parents admit an incomplete knowledge of sexual development and appreciate the chance to acquire information. Three out of four youngsters have indicated that they would attend other similar programs.

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81P-1439

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November 1982

CURRENT AWARENESS IN HEALTH EDUCATION

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CURRENT AWARENESS IN HEALTH EDUCATION

NOVEMBER 1982

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INTRODUCTION

Current Awareness in Health Education (CAHE) is published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents acquired and selected by the Center. CAHE also contains descriptions of programs in health education. These descriptions are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources. To make the information in CAHE timely, only documents published or programs of relevance since 1977 are included.

Copies of each document and supporting documentation for each program description are stored in the Center's permanent collection. Users of CAHE are urged to consult local public, medical, and university libraries for individual copies. Sufficient information is provided in the citations to enable users to locate copies or to contact programs.

All persons receiving CAHE are invited to contribute copies of pertinent documents and descriptions of relevant programs for possible inclusion. The Center also welcomes any comments on CAHE and suggestions to improve its usefulness. Write or call:

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Education
Building 14
Atlanta, GA 30333
(404) 329-3235
FTS 236-3235

Tearsheets for submitting program documents and descriptions of relevant programs are provided on pages vii-viii.

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HOW TO USE CAHE

CAHE contains two types of records: informative abstracts of published literature and descriptions of ongoing programs. These records are arranged in chapters according to their major subject area. Chapter headings are used to group items generally related and include: Community Health Education; Health Education in Occupational Settings; Health Education Methodology; Patient Education; Professional Education and Training; Regulation, Legislation, and Administration; Research and Evaluation; Risk Reduction; School Health Education; Self-Care; and Sex Education. The chapter headings reflect active areas in health education as well as major interests of the Center for Health Promotion and Education. To locate specific items of interest, users are encouraged to use the extensive Subject, Author, and Program Title indexes found in the back of each issue.

Within each chapter, citations and abstracts of documents appear first, followed by descriptions of programs. Abstracts with their citations are arranged in alphabetical order by the primary author's name, and descriptions of programs are arranged in alphabetical order by the title of the program.

Each document and program description has a unique accession number. Accession numbers of documents consist of a two-digit prefix indicating the year of acquisition by CAHE and a four-digit number indicating the publication sequence of the document. For example, 79-0022 indicates the 22nd document acquired by CAHE in 1979. Program accession numbers have a similar format with a "P" added following the year to indicate program, e.g., 79P-0025 indicates the 25th item acquired by CAHE in 1979, and that the item is a program.

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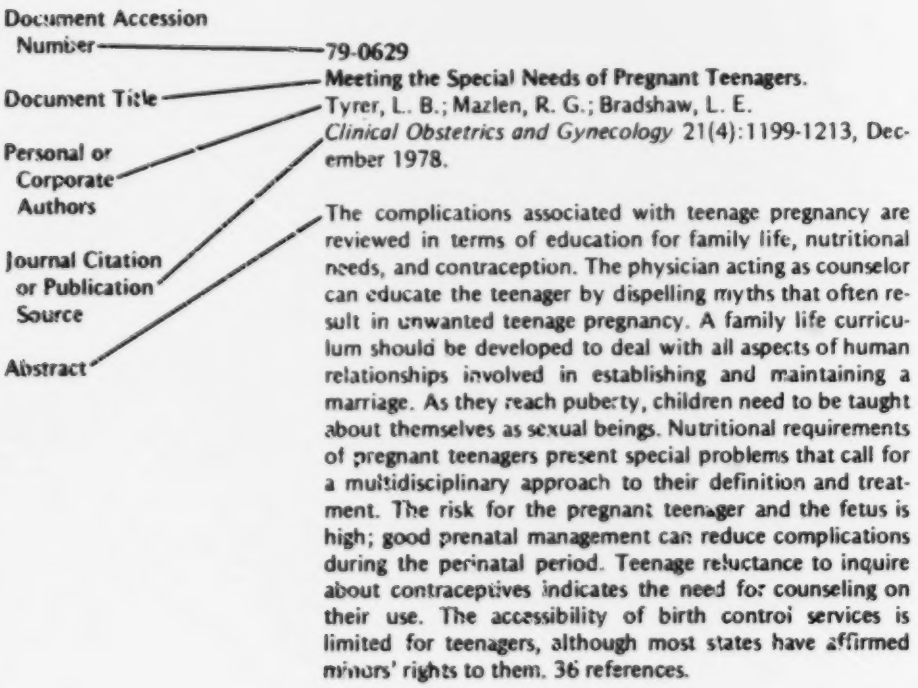
Document Accession Number
79-0629
Document Title
Meeting the Special Needs of Pregnant Teenagers.
Personal or Corporate Authors
Tyrer, L. B.; Mazlen, R. G.; Bradshaw, L. E.
Journal Citation or Publication Source
Clinical Obstetrics and Gynecology 21(4):1199-1213, December 1978.
Abstract
The complications associated with teenage pregnancy are reviewed in terms of education for family life, nutritional needs, and contraception. The physician acting as counselor can educate the teenager by dispelling myths that often result in unwanted teenage pregnancy. A family life curriculum should be developed to deal with all aspects of human relationships involved in establishing and maintaining a marriage. As they reach puberty, children need to be taught about themselves as sexual beings. Nutritional requirements of pregnant teenagers present special problems that call for a multidisciplinary approach to their definition and treatment. The risk for the pregnant teenager and the fetus is high; good prenatal management can reduce complications during the perinatal period. Teenage reluctance to inquire about contraceptives indicates the need for counseling on their use. The accessibility of birth control services is limited for teenagers, although most states have affirmed minors' rights to them. 36 references.

The distributor from which a document cited in CAHE is available to the public may be given as the last element in the citation. The most commonly cited distributors and their acronyms are listed below. Price information may be obtained from the supplier at the address given by specifying the order or stock number of the document and the form, hard copy or microfiche, desired. If the document is available from a distributor other than those listed, such as directly from the author, the address of that alternate distributor is provided.

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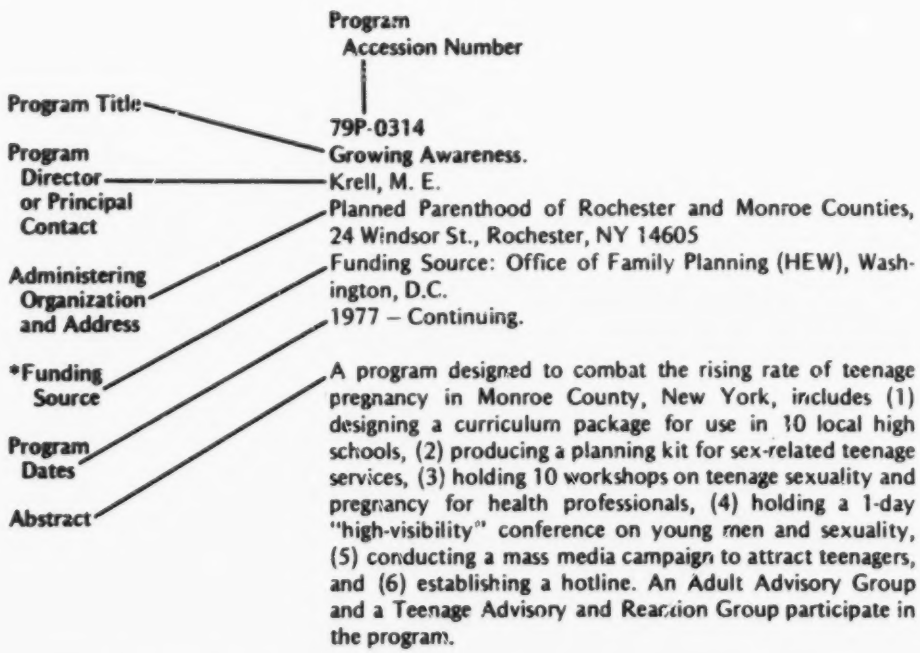
Program Accession Number
Program Title
Program Director or Principal Contact
Administering Organization and Address
*Funding Source
Program Dates
Abstract
79P-0314
Growing Awareness.
Krell, M. E.
Planned Parenthood of Rochester and Monroe Counties, 24 Windsor St., Rochester, NY 14605
Funding Source: Office of Family Planning (HEW), Washington, D.C.
1977 – Continuing.
A program designed to combat the rising rate of teenage pregnancy in Monroe County, New York, includes (1) designing a curriculum package for use in 10 local high schools, (2) producing a planning kit for sex-related teenage services, (3) holding 10 workshops on teenage sexuality and pregnancy for health professionals, (4) holding a 1-day "high-visibility" conference on young men and sexuality, (5) conducting a mass media campaign to attract teenagers, and (6) establishing a hotline. An Adult Advisory Group and a Teenage Advisory and Reaction Group participate in the program.

CAHE contains three indexes. They are: (1) Author, which contains the names of personal and corporate authors of documents and directors of programs; (2) Subject, which contains subject descriptors, including geographic location, for both documents and programs; and (3) Program Title, which contains names of programs that are either mentioned in documents or detailed in program descriptions.

*The funding source is specified if the program receives funds from institutions other than the administering organization.

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PROGRAM DATA SHEET

The Center for Health Promotion and Education is collecting information about current health education programs for use in *Current Awareness in Health Education* and in analyzing program trends in the field. A program may provide identification, public awareness, coordination, training, demonstration, etc.

If you wish to share your program efforts with other health education professionals, please complete the form below, being as specific as possible in providing information.

We greatly appreciate your taking the time to share your experience with us.

---

1. Program Identification:

   Official Title of Program or Grant and Grant No: _____

   Official Name of the Organization Conducting the Program: _____

   _____

   Address of the Organization:

   _____
   street city state zip code

   Program Director: _____
   name title telephone area code number

   Principal Contact: _____
   (if different from Program Director) name title telephone area code number

   Beginning Date of Program _____ _____ Ending Date, If known: _____

2. Funding Source for Your Program:

   Please provide the Name(s) and Location(s) (City, State) of Funding Source(s):

   _____

   _____

   _____

3. Focus of Program: _____Administration _____Community Health Education _____Health Education Methodology

   _____Nutrition Education _____Occupational Health Education _____Patient Education

   _____Professional Training Programs _____Research and Evaluation _____Risk Reduction _____Sex Education

   _____School Health Education Other _____

4. Target Population(s): _____

5. Purpose of Program: Please describe the primary purpose of your program

   _____

   _____

   _____

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   _____

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   _____

6. Publications/Information Materials: Please send copies of any publications or material describing your program, if available, or give complete citation (author, title, date, publisher). If no publications exist or are planned, please state how further information may be obtained.

   _____

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THANK YOU.

Name, Title of Person Submitting Program Information

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COMMUNITY HEALTH EDUCATION

81-1440
Perspectives on Medical Service at an Urban HMO.
Urban Health 9(10):38-42, December 1980.

The chief of obstetrics and gynecology, the medical director, and the medical affairs director of Comprehensive Health Services of Detroit (CHSD), a health maintenance organization (HMO), were interviewed concerning the nature of medical problems among members and issues in health care service affecting the patient population. CHSD provides HMO services to over 28,000 patients, most of whom are inner-city Medicaid patients. Over 60 percent of CHSD's 1979 members were under 19 years old. The organization provided a total of 78,945 patient-physician encounters during 1979 through the New Center Medical Plaza Group. The low-income patients' medical orientation toward crisis care is being overcome through financial help offered by Medicaid, but health education efforts are required to break poor health habits such as irregular eating, sharing medications, and relying on emergency care. CHSD provides health education on pregnancy and childbirth, hypertension, and diabetes. Telephone followup and other followup methods are used extensively. School health education, including components to address contraception, family planning, and nutrition would go far in helping inner-city HMO's to overcome cultural and socioeconomic barriers to forming proper health maintenance practices.

81-1441
Frost Valley and High Level Wellness: A Very Special Summer Camp.
Ardell, D. B.
Holistic Health Review 3(1):37-50, Fall 1979.

The Frost Valley Young Men's Christian Association (YMCA) summer camp in upstate New York offers a heterogeneous group of children and teenagers the opportunity to learn high-level wellness lifestyle skills via innovative programming. Self-responsibility, nutritional awareness, fitness, stress management, and environmental health are the main emphases of a broad health education program that is presented and reinforced in a variety of ways. Evaluation of the impact of the camp's methods indicated that the children enjoy learning wellness principles and skills, especially when learning opportunities are participatory and affective. Counselors play important roles by modeling and providing support. Peer group pressure can be a positive force in a low-key environment that promotes simple messages about health-enhancing behaviors. The professional staff of the Frost Valley YMCA summer camp program was assisted by the Wellness Coordinating Committee.

81-1442
High Level Wellness and the HSAs: A Health Planning Success Story.
Ardell, D. B.
American Journal of Health Planning 3(3):1-18, July 1978.

A questionnaire was sent to 198 health systems agencies (HSA's) to assess the number and types of high-level wellness or health promotion programs implemented by these agencies. Of the 60 respondents, 20 are wellness-oriented planning organizations, of which 14 offer a clear definition of wellness and health promotion; 17 have an articulated wellness framework; 3 have an inventory of wellness resources; 16 sponsor public education on wellness; 10 present wellness as a cost-containment effort; 8 attempt to influence public policy toward wellness; 4 provide wellness programs for their employees; 7 provide wellness programs for hospitals; 11 provide wellness programs for health providers; 14 provide wellness programs for schools; and 8 encourage health insurance programs to reimburse policyholders for wellness activities. These findings suggest that (1) Federal support for wellness efforts by HSA's would meet with success; (2) services should be developed to disseminate model wellness programs; and (3) standardized personal training practices, terms for health promotion and wellness, and wellness performance criteria should be developed. 8 references.

81-1443
Pharmacy: A Unique Opportunity to Participate in Education.
Barnett, J. W.
Health and Social Service Journal (London) 90(4688):479-480, April 11, 1980.

The proliferation of high-potency drugs demands a concomitant increase in public awareness that can be best met by pharmacists adopting the role of educator. Such personal initiatives as addressing meetings or media audiences could be combined with promoting public awareness in local areas. Other vital roles for pharmacists include health education consultations in schools and

coordinating efforts with general practice pharmacists, who in turn reinforce the doctors' responsibility for information to patients. Problems related to the use of medicines by patients include excessive self-medication, adverse reactions or side effects, addiction, improper drug storage resulting in deterioration, and failure to dispose of redundant medications. Efforts for increased public awareness must avoid exacerbating the pervasive problem of patient noncompliance with medication regimens.

81-1444
The Innovation and Implementation of Appropriate Health Education.
Clarke, W. D.
Proceedings of the Royal Society of London. Series B.: Biological Sciences (London) 209(1174):141-145, July 1980.

Implementation of effective and appropriate health education programs for developing countries requires that health planners overcome the tendency to place all health education efforts in one category. The planner must clearly understand the primary, secondary, or tertiary nature of the health education intervention to be implemented. Next, the planner must review the available techniques and media to decide the form of innovation that is to be implemented. Use of advertising as opposed to educating schemes, emphasis on development of skills, and extensive use of auditory as opposed to visual media are most appropriate for populations in developing countries. Dramatic presentations constitute a particulary effective form of health education communication in third world countries. In the distinct area of implementation, planners must identify potential obstacles to program development, take a broad view of health education to include social and environmental factors, and understand the sequential cognitive and behavioral stages people must pass through before adopting or rejecting an innovation. 7 references.

81-1445
Planning the Educational Component of a Hypertension Control Program: A Case Study.
Cleary, H. P.; Kornacki, M. J.; and Grancio, S.
Health Education Quarterly 7(4):263-277, Winter 1980.

Experiences from a State-financed hypertension control project at the University of Massachusetts Medical School indicate that planning the health education component is an inseparable part of the total planning effort of a health service program. The Massachusetts State Health Department simultaneously funded five ambulatory facilities and five boards of health to provide high blood pressure screening and intervention programs. It also funded a university medical center to provide training for nurses working in the ambulatory facilities and boards of health. The trainers, who included a project director, health educator, and nurse educator, held a 2-day workshop for 57 nurses and a few administrative personnel. A needs assessment questionnaire was completed by the nurses prior to the workshop. Both the questionnaire and workshop experiences indicated that the nurses had pronounced deficits regarding provision of community control services and that they felt themselves to be independent of the State health department in the performance of the project. As a result the nine institutions that remained in the program received onsite visits to provide individulalized training for nurses. In addition, 14 workshops were held. Onsite evaluations of the project institutions indicated that the needs assessment phase had not been comprehensive enough, resulting in inadequate allocation of equipment, poor attitudes on the part of staff, and lack of properly defined organizational policy. As a result, key relations between project staff and area physicians were weak or nonexistent. 16 references.

81-1446
The Right to Quality Life: A Challenge for Parenting Education.
Gaines, J.
Health Education 12(2):18-20, March-April 1981.

Parenting education, including instruction concerning the health-related effects of lifestyles on the unborn, is an essential component of education for responsible human sexuality. Studies have indicated that knowledge of pregnancy motivates mothers to modify substance use. Timely educational interventions concerning the effects of alcohol, tobacco, drug use, and malnutrition on the unborn infant would reinforce the motivation of mothers to curtail substance use and improve prenatal nutrition patterns. Parenting education should include information concerning the poor outcomes of teenage pregnancies for both mother and child. Overall, expectant parents and teenagers should constitute target groups for specially designed parenting education programs. 16 references.

81-1447
A New Look at Community Dental Health.
Hayden, H.; Jenny, J.; and Frazier, P. J.
Dental Hygiene 52(4):167-174, April 1978.

In December 1977, the American Dental Hygiene Association District VIII Workshop met to examine innovative strategies, analyze problems, and devise alternative

solutions for improving community dental health. Workshop participants were instructed to design ideal dental health programs for a series of hypothetical communities and to develop a national dental health plan. Seven dimensions were combined in various ways to produce the prototype community sketches: (1) urban, rural; (2) degree of mobility; (3) water fluoridation; (4) population size; (5) age; (6) socioeconomic status; and (7) ethnic composition. Groups considered the interrelationships of types of dental care services to be delivered, manpower requirements, facilities, distribution of facilities and manpower, sources of funding, support of research, and application of research findings. Also suggested for consideration were development of dental manpower; incentives for professionals to provide services for the particular type of community; ways to overcome the financial barriers to dental care; legislation that meets dental care demands; creating positive attitudes and behaviors in providers and consumers; application of available preventive approaches; research; systems developed in other countries; community and school programs; and water supply fluoridation. Each group devised a unique, multifaceted plan tailored to the specific needs of one of the six types. Strategies proposed by almost every group included removing junk foods from schools, implementing school-based dental care programs and water fluoridation, expanding health personnel, and establishing accessible community clinics. Recommendations for a national health plan entailed (1) services, (2) manpower and education; (3) quality control; (4) facilities; (5) funding; and (6) research. 9 references.

81-1448
An Applied Dietetics Curriculum in an Alcohol Treatment Program.
Hynak, M. T. and Getsinger, S. H.
Journal of Alcohol and Drug Education 26(1):12-27, Fall 1980.

An applied dietetics module was designed for use in a 28-day, 17-bed intermediate treatment program at a Veterans Administration medical center. The patient population in the program ranges from 18 to 90 years old, but the mode is 30 to 45 years old. The program uses a full range of treatment modalities. The dietetics curriculum consists of two 1-hour presentations incorporating learning principles from the fields of education and psychology and using visual aids and written handouts to reinforce teaching. The overall objective of the course is to educate patients about the physical properties of alcohol, alcohol as a food and drug, alcohol-disulfiram reaction, nutritional effects of alcoholism, alcohol and liver disease, and other disorders associated with alcohol abuse. These general objectives have been subdivided into 23 subobjectives. Each subobjective is addressed individually during the two-session course. Parameters for assessing the success of this learning experience include individual patient comments, observed group interaction, observed attitudinal changes, and verbal feedback to staff members. 41 references.

81-1449
Learning From Real-Life Problems: Functional Education in Bangladesh.
Islam, M. A.
Ceres 13(1):29-32, January-February 1980.

In response to continuing high birth rates among the poor, rural majority of the Bangladesh population, the Bangladesh Rural Advancement Committee (BRAC) introduced an innovative public awareness program to help the rural poor understand their social and economic problems. The program consists of functional education, village workshops, and a women's program. Initiated as an adult literacy program in 1974, the education component involves 60 2-hour lessons to promote literacy and practical mathematical ability by engaging the participants in problems associated with everyday life. The women's program attempts to form women's cooperatives and mothers' clubs to enhance acceptance of family planning. In village workshops, groups of men and women engage in analysis of their socioeconomic situation for 2 to 3 days. Informal evaluation of the BRAC program indicates that (1) the course completion rate for the functional education component has risen from 5 percent under the literacy approach to 50 percent under the functional approach; (2) the program appears to have increased participation in family planning; and (3) the program has combined effectively with poverty-focused rural development activities. A national health insurance scheme would enable such health education and family planning programs to be expanded. 6 references.

81-1450
An Examination of Spanish Speaking Patients' Sources of Over-the-Counter Drug Information.
Kelly, E. T. and Speranza, K. A.
Drug Intelligence and Clinical Pharmacy 12(3):169-171, March 1978.

Structured interviews with 55 Puerto Rican family representatives were undertaken to obtain the perception of Spanish-speaking people with regard to the credibility and accessibility of health professionals as over-the-counter (OTC) drug information sources and the use of mass media for disseminating drug information. The subjects

were residents from either a large urban area or a small rural industrial pocket in the northeastern United States. Analysis of the data using Kendall's Coefficient of Concordance indicated that (1) nonprofessionals did not constitute significant sources of drug information; (2) the physician was considered the most reliable and accessible information source, followed by the visiting nurse and pharmacist; and (3) television, newspapers, magazines, and books, respectively, were the most desirable media sources. The high ranking of nurses and pharmacists as drug educators suggests that future programs for the Spanish-speaking community should emphasize these providers. Since the subjects favored verbal communication over written communication, the use of television and radio is an appropriate choice for disseminating drug information to low-income Spanish-speaking people. 6 references.

81-1451
Public Cancer Education.
Lowry, S.
Health Education Journal (London) 38(1):23-29, 1979.

Clinical and epidemiological trends in the field of cancer control indicate that public education efforts directed at prevention and early detection will be more successful than efforts in the area of treatment. Suprisingly, it appears that, few forms of cancer (besides smoking-induced cancers) are amenable to preventive health education measures. Numerous early symptoms associated with malignancies permit early detection by those knowledgeable about these signs. Four steps in public cancer education are (1) defining the message, (2) presenting the message to the audience, (3) changing the behavior of the audience, and (4) improving ultimate survival of the audience. Educational interventions have been successful in stemming the rate of lung cancer, melanoma, carcinoma of the cervix, colon cancer, and breast cancer. The American Cancer Society has been particularly effective in its use of educational interventions. Thus, demands by the public and professional sectors for absolute proof of the efficacy of educational programming for cancer detection and prevention seems counterproductive. Warning the public to watch for unusual symptoms, lumps or bumps, abnormal bleeding, and skin and mouth lesions is common sense. Great Britain needs a major organization to back public and professional cancer education. 1 reference.

81-1452
The Role of the Community Health Educator on the Primary Health Care Team.
Reagan, P. A.
Health Education 12(2):28-31, March-April 1981.

The Colorado Migrant Health Program (CMHP) demonstrates the effectiveness of the community health educator as a member of an interdisciplinary health care team. Program teams include student physicians, dentists, dental assistants, nurses, nurse practitioners, physician's assistants, and health educators. In 1978, 141 students served on 29 teams. To evaluate their summer experience, daily activity sheets, exit interviews, faculty observations, and faculty consultations were conducted, and a statistical analysis was drawn. The health educator proved valuable in bridging the gap between acute care and prevention. When all team members understand the health educator's role on their "territory" and the legitimacy of health education in primary care, the health educator can effectively plan and implement health education activities with each member. The educators' preparation should enable them to perform a variety of clinical and community referral skills, including screening and assessing migrant schoolchildren, performing educational programs for small groups or individuals in the clinic, teaching specific courses, serving as a resource person on cultural or health topics, and conducting inservice courses for team members and migrant school teachers. Program health educators desired more training in patient education, medical terminology, teaching stategies, in-school experience, and community organization. 3 references.

81-1453
Primary Prevention of Coronary Heart Disease: The Last 20 Years.
Stamler, J.
American Journal of Cardiology 47(3):722-735, March 1981.

A review of policies and programs related to the prevention of coronary heart disease (CHD) over the past 20 years indicates that these efforts have resulted in a decline in mortality from CHD during the last decade. Major policy makers in the field have included the American Heart Association; the Surgeon General; the Inter-Society Commission for Heart Disease Resources; the White House Conference on Nutrition; the Task Force on Arteriosclerosis; the Department of Health, Education, and Welfare; the National Heart, Lung, and Blood Institute; the Select Committee on Nutrition and Human Needs of the U.S. Senate; and the American Diabetes Association. While massive programs were being mounted through, or in reaction to, the actions of these bodies, the eating patterns, serum cholesterol levels, cigarette smoking patterns, exercise patterns, and hypertension rates of the U.S. population underwent significant positive changes. As a result, it appears that national mortality and morbidity rates associated with CHD have declined dramatically.

Numerous epidemiological studies attest to these declines and to declines in other regions of the world where similar efforts were and are being mounted. 81 references.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-1454
Long-Term Hypertension Control: It Can Be Done.
Alderman, M. H. and Stanback, M. E.
Urban Health 7(5):42-45, June 1978.

The Cornell Work-Site Detection and Treatment Program implemented a hypertension intervention program for employees of Gimbels' and Bloomingdale's department stores (New York) in the spring of 1973. Components of the program include provision of care in a way that makes it convenient and accessible to the employees, adherence to a rigid therapeutic program, reliance on a physician-led health team for the delivery of services, and a vigorous effort to enhance the patients' understanding of the disease and its treatment. Paraprofessionals or nurses are responsible for much of the care delivered. The successful hypertension intervention programs of the U.S. Public Health Service Hospitals, the Veterans Administration, and the Hypertension Detection and Followup Program (HDFP) served as models for a health education program implemented by Cornell University. The program employed a stepped-care protocol, involving initial use of a diuretic with staged addition of higher doses and other antihypertensive drugs as necessary. Therapeutic complications were few. Although the major problem affecting this type of program is patient attrition, patient dropout rates were significantly lower than those for typical hospital programs. These programs, particularly the Cornell and HDFP programs, which are community-based efforts, have proven vastly more successful than conventional programs due to use of widely applicable drug protocol, abandonment of fee-for-service financing, systematic education and followup, and easy accessibility. 13 references.

81-1455
Hypertension Management in an Occupational Setting.
Coleman, V. R.
Occupational Health Nursing 27(5):13-15, May 1979.

The goals of occupational health nursing and public health nursing are tightly interwoven in confronting the challenges of hypertension. Any employee found to be affected by hypertension must be educated about the disease, treated or referred for treatment, and followed through treatment to assure compliance to the prescribed regimen. In a program at Cornell, patients with three consecutive readings of high blood pressure are referred to an educational program that informs them of the chronic nature of the disease and the consequent need for extended therapy and periodic blood pressure measurements. Beliefs that other medications or alcohol cannot be taken with antihypertensive medications must be corrected, and the asymptomatic nature of the disease explained. Referral to physicians must be systematically followed up, or the patient's treatment must be monitored by the occupational nurse. The Cornell program began with a publicity campaign and a screening program implemented with the cooperation of the union. Of the 3,000 employees screened, 481 were found to be hypertensive and 269 joined the treatment program. After further screening, the patients received drugs and a printed protocol explaining the regimen. The nurses became the primary source of hypertensive care and followup, and several programs aimed at correcting conditions associated with hypertension were begun. 4 references.

81-1456
The Cummins Engine Company Stop Smoking Program.
Miller, G. H. and Rodway, J. S.
Journal of the Indiana State Medical Association 73(4):233, April 1980.

A unique program to assist employees to stop smoking permanently was inaugurated at Cummins Engine Company in Columbus, Indiana. The SOS Stop Smoking Clinic consists of a 1-year course backed by a company vice-president and two physicians at the Columbus Occupational Health Association. After assessing employee interest by means of questionnaires, two classes with a total of 33 participants began on August 20, 1979. The clinic makes use of research by the instructor, who designed a reverse peer pressure system that utilized family members and a "buddy system" to help smokers give up the habit. Individual and group counseling is provided to all participants and special sessions are provided for persons with special difficulties. The efficacy of the 15-session clinic is assessed by measuring the carbon monoxide levels in participants' breath. After 4.5 months, 23 of the participants had stopped smoking, 6 participants were still trying to stop, and 4 participants had resumed smoking. A complete report was to be prepared in August 1980.

81-1457
Safety and Health Instructional Materials for Vocational Education--A State-of-the-Art Report.
Technical Education Research Center - Southwest, Waco, Tex.
Waco, Tex., the Center (Task D Report, Contract No. 300-79-0709: Development of Safety and Health Instructional Materials), 445 p., May 1980.

In October 1979, under Programs of National Significance of the Vocational Education Act of 1963, the Office of Education, Bureau of Occupational and Adult Education founded a program with the Technical Educational Research Center (Texas). The project seeks to augment and enrich existing and newly created safety and health instructional materials, and to increase the skills and knowledge related to the safety and health of workers, including factors affecting their work environment. Performance-based modularized instructional materials will be developed for teaching job safety in secondary and adult vocational educational programs. One of the tasks of the program is to conduct a search and prepare a state of the art report on occupational safety and health instructional materials for each of 15 occupational clusters. The materials will form the basis for the development of 50 educational modules in the occupational areas. Occupational areas under which materials have been collected and arranged include agriculture, business and office areas, communication and media, construction, fine arts and humanities home economics, health, hospitality and recreation, manufacturing, marine science, marketing and distribution, natural resources and environment, personal services, public service, and transportation. The most prevalent form discovered in the search was the 16mm film; the second most abundant format was the single-concept pamphlet. Manufacturing and construction clusters have received the most attention by developers of safety and health information materials. The review found only five student-oriented modules that were suitable for revision, indicating the need to develop new modules.

HEALTH EDUCATION METHODOLOGY

81-1458
What Can Nutrition Educators Learn from Communication Theories?
Alexander, J. K.
Journal of Nutrition Education 13(1, Suppl. 1):S27-S28, 1981.

The interrelation of communication theory and nutrition education research addresses a number of key issues that must be faced by nutrition educators. These issues include identification of audience, the relationship between communication theory and nutrition behavior, the time needed to assess the effectiveness of a nutrition education program or related research effort, the effects of various media, guidelines for communication planning, marketing versus nutrition education, the congruence of nutrition education methods with the intentions of nutrition educators, measurement of constantly changing independent variables, and multidisciplinary approaches to nutrition education. The Stanford Heart Disease Prevention Program Five-City Project constitutes a good example of the application of communication theory to nutrition education programs for a general population. The program, which includes mass media campaigns, school programs, training workshops for professionals, and a number of community events and activities, includes a nutrition education component designed to reduce cardiac risk factors for the 120,000 persons living in the target area. 2 references.

81-1459
Development of a Computer-Assisted Program for Undergraduate Instruction.
Asp, E. H. and Gordon, J.
Journal of Nutrition Education 13(1, Suppl. 1):S91-S95, 1981.

Research conducted in the introductory food decision-making course offered by the Department of Food Science and Nutrition at the University of Minnesota integrated menu-planning concepts, teaching and learning theory, and computer-assisted instruction (CAI) to develop an interactive computer-assisted menu planning program. Development of a conceptual structure for food decision making required inputs from a number of disciplines, including nutrition, food science, economics, marketing, sociology, psychology, anthropology, physiology, education, and food and meal management. General instructional objectives and specific learning outcomes were developed for six major educational levels, namely, knowledge, comprehension, application, analysis, synthesis, and evaluation. The questions, exercises, and simulations were limited to two food factors (nutrient content and sensory attributes such as color, flavor, texture, shape, and temperature) and two human factors (nutrient needs and food habits). The first part of the CAI, known as the MENU program, used a question-and-answer format to assist the user in evaluating the menu at each level. The second part, known as the TALLY program, was a simulation section in which the user changed the foods in

the menu to adjust nutrient and improve sensory attributes. A controlled study involving 60 students and 10 professional menu planners revealed that (1) no student developed an ideal menu; (2) both experts and students had difficulty in using sensory attribute information; and (3) nutrient information was used better than sensory information. Integration of the MENU program into normal course work contributed to students' learning experience at several educational levels. 22 references.

81-1460
Self-Examination of Paraoral Tissues for Detection of Early Oral Cancer.
Atterbury, R. A.
Dental Survey 55(12):18-24, 54, December 1979.

Self-examination of the paraoral tissues can help detect early symptoms of oral cancer. In contrast to benign tumors, malignant tumors are characterized by rapid growth, inflammatory reactions around the tumor, white and red areas, ulcers, elevated masses, and unusual pigmentation. Dentist and patients should be alert for fleshy-looking buds of tissue; warty, flat, leukoplakic plaque; small fissures; infiltrated ulcers; and scaly-looking lesions and induration. The self-examination procedure should proceed from the extraoral structures to the anterior intraoral structures and the posterior oral structures and pharynx. After careful inspection, the same areas should be thoroughly palpated with the fingers to detect any areas of swelling, roughness, induration, or asymmetry. Finally, persons should examine all aspects of the teeth and gingivae, noting any irregularities of the gum tissue or in color or texture. Mucosal thickening, erosions, and advanced leukoplakic plaque are early signs of gingival carcinoma. 10 references.

81-1461
ICEA Film Directory with Teaching Aids Supplement.
Caldwell, L. K., ed.
9th ed. Milwaukee, Wis., International Childbirth Education Association, 53 p., September 1978.

Citations of films and other teaching aids for childbirth education and family planning programs are provided. Film subjects include cesarean birth, childbirth and childbirth education, fetal development, early childhood, home birth, infant and child health care, infant and child hospitalization, infant feeding and breast-feeding, infant growth and development, outreach, parenting, the postpartum period, pregnancy, and sex education. A supplement on teaching aids includes filmstrips, records, slides, sound cassettes, reel-to-reel tapes, charts, booklets, and public service announcements for television that are adaptable for advertising local organizations. Citations for films include lengths, prices, and sources as well as descriptive annotations. Films in Spanish, French, and Italian are also listed.

81-1462
Eating--A Psychological Dilemma.
Coates, T. J.
Journal of Nutrition Education 13(1, Suppl. 1):S34-S48, 1981.

Psychologists have provided nutrition education models for explaining food choice, strategies for treating obesity, strategies for comprehensive nutrition education programs, and strategies for individual counseling. The early model depicting the internal versus external eating styles of persons with normal weights versus obese persons (persons with normal weight eat from physiological cues, obese persons eat because of external cues like time of day or the sight or smell of food) has been refined to account for hypertrophy and hyperplasia, restraint in eating, and primary externality and reciprocal internality. Early strategists treating obesity emphasized behavior modification because (1) weight is the final element in a chain of responses; (2) eating and exercise do not occur in isolation; and (3) behavioral consequences affect the probability of variations in future behavior. The next generation of strategies relied more directly on research in behavioral self-management, though this theoretical shift has done little to affect the methods used. Promising trends in treatment include behavioral prescriptions based on behavioral analyses of subjects, behavioral rehearsals, emphasis on early weight loss and daily contact, contingency arrangements, family involvement, and individualized treatment. Community behavior change strategies have emphasized social learning theory and personal influence skills. The Heart Health Program and the Stanford Three-Community Study are exemplary programs in community nutrition education.

81-1463
The Relations of Behavioral Sciences and Health Education.
Cosico, R. C. F.
Newsette; Department of Health National League of Nurses 18(4):7-10, October-December 1978.

Health education must have as its ultimate goal the public practice of the knowledge imparted, as well as a change in attitude within the target population. In order to effect this goal, the health educator needs an understanding of

the behavioral sciences such as sociology, anthropology, and psychology. Knowledge, attitude, and practice are an interplay of tendencies that are rooted deep within cultural, social, and personal experiences and may be acquired either directly or indirectly. It is the responsibility of the health educator to dig deep into these underlying roots in order to achieve success.

81-1464
Social Psychological Perspectives and Applications to Nutrition Education.
Glanz, K.
Journal of Nutrition Education 13(1, Suppl. 1):S66-S69, 1981.

A critical overview of the prevailing assumptions and methods used in nutrition education practice and research provides background for (1) an assessment of alternative means of studying and intervening in nutrition behaviors and (2) discussion of programmatic and methodological issues which have limited the application of existing theories and data. Most efforts to change dietary behavior in the United States emphasize overconsumption of the wrong foods. Dietary recommendations are restrictive rather than additive and require changes in basic lifestyle behaviors. Though commercial advertising efforts have demonstrated success in the marketing of foods, the triviality of decisions involved, the extreme costliness of the efforts, and the small scope of the targeted change make such tactics of little interest to nutrition educators. Analysis of decision making in food consumption can direct nutritionists to target individuals and identify temporal and environmental points for intervention. The two broad categories of intervention strategies that are available are structural interventions and direct influence attempts. Structural intervention involves adaptation of strategies into usable techniques for practice, while direct influence attempts to address knowledge, attitudes, and behaviors. These categories apply to both lay persons and professionals. Important methodological concerns in the area of evaluation include formulation of evaluation schemes, quality of information collection and analysis, use of evaluative information, and the timing of outcome measures. 25 references.

81-1465
Cognitive Assist in Motor Learning.
Gonnella, C.
International Journal of Rehabilitation Research. Internationale Zeitschrift fur Rehabilitationsforschung. Revue Internationale de Recherches de Readaptation (Rheinstetten) 3(4):568-569, 1980.

The Emory University Rehabilitation Research and Training Center at Atlanta, Georgia, is investigating the potential of self-instruction in certain aspects of learning a rehabilitation motor skill. The learning of a motor skill involves cognitive integration, perceptual-motor integration, and sensory-motor integration. The project began by investigating the possibility of separating the cognitive phase from the other phases and programming this phase into an instructional package under patient control. Using the three-point crutch gait as the target skill, a 9.39-minute audiovisual presentation was developed and tested with 40 normal female subjects. The presentation does not rely on dividing the skill into components; rather, the walking pattern is shown at normal and slow speeds, with closeup views to emphasize key aspects. The subjects were involved in two separate controlled experiments. Results of the experiments indicated that (1) one showing of the tape allowed subjects to gain a sufficient cognitive understanding of the gait, (2) use of practice trials before and after the presentation demonstrated that successful performance was possible without formal instruction, and (3) subjects who previewed the film before any practice sessions responded positively during the practice sessions. The presentation will be tested with patients to determine its effectiveness with handicapped populations and its administrative feasibility. 2 references.

81-1466
Consumer Health Education.
Health Systems Agency of Southwestern Pennsylvania, Pittsburgh.
Pittsburgh, Pa., the Agency, (Guidelines Series), 32 p., September 1978.
Available from: NTIS; Order No. HRP-0030090.

Guidelines for planning and developing community-oriented consumer health education are presented for providers of health services and communities interested in the development or evaluation of such a system. Topics include developing qualitative and quantitative guidelines, identifying and using community resources, coordinating programming, designing and implementing research on programming, eliciting the participation of consumers, utilizing new approaches to health education, financing programs, evaluating interventions, establishing target populations, identifying health problems, identifying and assessing existing programs, and identifying the relationships among resources and programs and the problems they confront. A selected bibliography, a list of resource persons used by the area health systems agency, and a schematic delineation of the planning process are appended.

81-1467
Strategies and Their Rationale for Changing People's Eating Habits.
Hochbaum, G. M.
Journal of Nutrition Education 13(1, Suppl. 1):S59-S65, 1981.

Early nutrition education programs, which emphasized widely accepted social values, fear-inducing techniques, and provision of information, have given way to programs emphasizing preprogram psychosocial analyses, subjective perceptions of health problems, lifestyle interventions, and social environments. Nutrition education has relied on surveys of people's knowledge and practices, research on physiological factors, and research on psychological factors. The experimental nature, theoretical orientation, lack of interdisciplinary integration, and unidimensional approach characterizing most research studies have detracted from the applicability of findings. Psychosocial influences on health behavior prevent simple nutrition knowledge from having a significant effect on human eating behavior. Application of the principles of the Health Belief Model to nutrition education research neglects motivations for behavior that transcend the desire to be healthy. Current research directs itself almost exclusively to the nutritional problems of individuals, resulting in few findings of value to change the habits of large populations. Successful community nutrition education programs in the future will emphasize the positive aspects of good nutrition, treat psychosocial and economic as well as situational factors as equally important, evaluate cognitive and short- and long-term behavioral changes due to programming, and emphasize adoption and maintenance of new behaviors. 10 references.

81-1468
Self-Instruction for the Family of a Child with Cystic Fibrosis.
Johnson, M. P.
MCN: American Journal of Maternal Child Nursing 5(5):345-348, September-October 1980.

Parents of children affected by cystic fibrosis at North Carolina Memorial Hospital are given a self-instructional booklet that contains basic information about the disease. The programmed booklet provides parents with a general understanding of the disease, encourages parents to become actively involved in rehabilitation efforts, and provides the nurse with a concrete tool for evaluating the parents' level of understanding. The book provides information on genetics, the underlying problem of thickening secretions, common pulmonary and gastrointestinal symptoms, and means of treating symptoms. Each section of the book contains a brief explanation of the topic, questions about the material covered, and answers to the questions to help the reader evaluate his knowledge of the material. A posttest provides the nurse and other health team members with the parents' understanding of disease-related information and their attitudes toward the presentation of the material and its pertinence. The booklet can be reused to reinforce and assess parental understanding of the disease. 1 reference.

81-1469
Inside Me: Teaching Anatomy to Children.
Marino, B. L.
Pediatric Nursing 6(3):37-38, May-June 1980.

A coloring book, entitled "Inside Me," has been developed to help children learn age-appropriate information about the human body. Distributed to children 3 to 10 years old at a health fair in Seattle, Washington, the books received the enthusiatic support of parents and teachers. The book, which includes information on nutrition and anatomy, has been adopted by nine area preschools and one hospital.

81-1470
Smoking and Health: An Annotated Bibliography of Public and Professional Education Materials.
National Cancer Inst. (DHHS, NIH), Bethesda, Md. Cancer Information Clearinghouse.
Bethesda, Md., the Clearinghouse (NIH Publication No. 81-1841), 82 p., November 1980.

Annotated citations of public and professional education materials concerning smoking and health are provided. Items cited include print and nonprint materials addressing risk and prevention for adolescents and adults, cessation, and nonsmokers' rights. Teaching resources, reference materials, and materials in French and Spanish are also cited. Title and subject indexes are appended. 290 citations.

81-1471
Facilitator's Handbook: Reflections in a Glass--A Course for Women.
National Center for Alcohol Education, Arlington, VA.
Rockville, Md., National Institute on Alcohol Abuse and Alcoholism (DHEW Publication No. (ADM)77-452), 79 p., 1977.

Guidelines for the implementation of an eight-session primary alcohol prevention course designed to help women confront their use and abuse of alcohol are offered for use

by lay persons interested in acting as course facilitators. The sessions address the effects of alcohol on bodily functions, drinking and driving, the influence of family and peers, reasons for drinking, the effects of alcohol in combination with other drugs, the influences of American history and popular media, the relationship between American history and women's use of alcohol, and personal standards for drinking. Notes for the facilitator include awareness of drinking attitudes, group norms on drinking, group participation, course assumptions, organization of course materials, and methods and media for presenting course content. A glossary and a list of resources are appended.

81-1472
Health: Nevada Competency-Based Adult High School Diploma Project.
Nevada Univ., Las Vegas. Coll. of Education.
Carson City, Nev., Nevada State Department of Education, Division of Adult, Continuing, and Community Education, 32 p., 1979.
Available from: ERIC; Order No. ED-183 749.

Guidelines for implementation of a one-semester health education curriculum designed by the Nevada Competency-Based Adult High School Diploma Project cover nutrition, reproduction, menstruation, contraception, alcohol abuse, tobacco use, immunization, disease, accident prevention, and emergency procedures. Competency statements and performance indicators are provided for each topic area. The performance indicators are designed to be used as pre- and posttests. The guidelines, which constitute one of ten sets developed by the project, are accompanied by both a teacher's guide and a student's handbook.

81-1473
1980 Indiana 4H Health and Safety Guide.
Purdue Univ., West Lafayette, Ind. Cooperative Extension Service.
West Lafayette, Ind., the Service, 1 v. (loose-leaf), 1980.

Planning and teaching guidelines are provided for 4-H Club officers appointed or elected as health or safety officers for the 1980 term. Topics proposed for the Indiana 4-H Club program include proper footwear, farm safety, prevention of eye injuries, safe use of chemicals, prevention of tractor accidents, automobile safety, proper responses to tornados, fatigue prevention, safe use of equipment and appliances, financial benefits of safe behavior, safe use of mowers, fire safety prevention and early warning devices, home safety, product safety, safety during the Christmas holidays, and safe use of snowmobiles. Health topics proposed include proper care of fingernails, emergency medical identification, first aid, immunization, care of burns, prevention of encephalitis, alcoholism, environmental health, smoking, rabies, weight control, skin care, eye care, nutrition, venereal disease, self-help, and dental health.

81-1474
Patient Education and Cost Containment.
Rome, L. P.
Ohio State Medical Journal 76(5):303-304, May 1980.

While patients have a primary role in containment of the cost of medical care, through measures such as health-promoting lifestyles, preventive medicine, safety precautions, and early diagnosis and treatment, the responsibility for curbing health spending is best met by a community-wide effort in health education. The Cost Containment and Patient Education Subcommittee of the Academy of Medicine of Cleveland monitors area patient education activities, identifies gaps and duplication in the educational activities of a variety of area and health agencies, and implements new strategies for cost containment through patient education. The plan encompasses efforts by individual patients, employers, community agencies, medical societies and health care providers. Among the suggested cost-cutting proposals are widespread periodic health appraisals by local health agencies, increased distribution of employee education films, first aid training for every household, a hospital categorization plan, referral of nonemergency patients to ambulatory care settings, coordination of an accident prevention program, and public use of industrial health clinics during nonworking hours. Particular emphasis is given to the use of audiovisual media and printed materials for patient and public health education in hospitals, clinics, physicians' offices, and community settings. Although the study involves the Cleveland area, all county medical societies can benefit by conducting their own study to determine strengths and weaknesses in their community's health education efforts.

81-1475
Renal Diet Therapy--A Computer-Assisted Instruction Model.
Schroeder, L. and Thiele, V. F.
Journal of Nutrition Education 13(1, Suppl. 1):S111-S114, 1981.

A computer-based educational system was developed and tested with 15 junior clinical nutrition majors and 19 senior general dietetics-nutrition science majors to deter-

mine if computer-assisted instruction (CAI) could be used as a primary means of teaching renal diet therapy. A study guide was written to teach the student how to combine the modified components of the renal diet prescription into menus. The development of the CAI model involved designing a CAI component and implementing it as an interactive program, formulation of an interactive experience for the student at the terminal which simulated one of the renal dietitian's responsibilities in the hospital, and formulation of a file system which included unit questions, answers, feedback information, menu items and their nutrient data, and records of all student work at the terminal. After pilot testing in spring 1978 to provide item analysis, a 25-item multiple choice pretest was administered to the 34 students. After involvement in the CAI unit, students were administered a 50-item posttest. Data from the tests indicated that (1) the CAI system succeeded as a primary means of teaching renal diet therapy; (2) students in the computer group found the computer enjoyable and efficient to use; and (3) the CAI unit gave the students more control over their educational experience than did the traditional approach. 19 references.

81-1476
Concepts in Community Participation: A Case of Sanitary Change in a Guatemalan Village.
Tonon, M. A.
International Journal of Health Education (Geneva) 23(4, Suppl.):16 p., October-December 1980.

A study of an educational program to help 300 Guatemalan villagers improve their sanitation skills was designed to investigate the social and behavioral constraints that affect programming and to examine program interventions and methodologies used to stimulate participation by villagers. A series of planning meetings with 25 patriarchal leaders initiated the program, and the group of leaders became an officially recognized planning body for the community. The committee developed guidelines for distribution of latrines, acceptable methods for controlling domestic animals, a women's educational program, a crisis intervention program during a food shortage, liaisons with the Minister of Agriculture, and household discussion forums on sanitation. The household forum program was preceded by intensive training of 30 volunteer forum leaders. Training sessions were held twice a week for 2 months. Seventy-three posters organized around six themes were developed for the forums. Later, three pamphlets were printed. More than 80 families participated in the first forum series. Outcomes were assessed by visiting sessions, taping sessions, and interviewing participants. All observations were positive, and eventually, a village cooperative was founded. These outcomes indicate the need to reinforce group autonomy, provide social recognition for program participants, attend to natural group change processes, and develop qualified field teams. 5 references.

81-1477
Health Care Maintenance for the Elderly.
Whitbourne, S. K. and Sperbeck, D. J.
Family and Community Health 3(4):11-27, February 1981.

When providing health education to the elderly, health care professionals should be aware of learning processes of the elderly and the transactional model of compensating for age-related changes. Conditions of learning that have been studied with respect to age differences in adulthood include the pacing or rate of information presentation, the type of instructions learners are given, the amount of negative interference, the amount of positive facilitation, the positive effects of practice, and the negative effects of fatigue. Factors within the learner that can influence the learning process include past experience with learning materials, strategy applied to different types of information, level of cognitive development, and emotional state during the learning situation. Health educators and care providers should be careful not to attribute behavioral limitations to elderly persons unless those limitations are objectively present and are not due to situational factors. Use of the transactional model, which promotes use of environmental supports to offset deficits due to aging, can help elderly persons compensate for changes in appearance, health and physical fitness, sensory or cognitive capabilities, personality and emotional attributes, and social roles. 38 references.

PATIENT EDUCATION

81-1478
Will PPIs Affect Your Patients' Attitudes?
Patient Care 13(3):190-191, 195-196, February 15, 1979.

Information offered at a patient package insert (PPI) conference sponsored by the Food and Drug Administration (FDA) and gathered through interviews with specialists in communications, practicing physicians, attorneys, and Government personnel indicates that the FDA will present a policy for PPI's. It will include a PPI priority list emphasizing agents for which patient decision making vis-a-vis use of the drug is a pertinent issue. If the policy is adopted,

contracts will be offered for writing an initial group of approximately 25 PPI's to be circulated in the next 2 to 3 years. Present FDA plans call for distribution of PPI's through pharmacists at the time drugs are dispensed. Various devices to measure PPI impact, excluding clinical trials, are being considered. Under an FDA contract, the Institute of Medicine, a component of the National Academy of Science, is investigating methods of assessing PPI impacts. Research indicates that PPI's have a positive short-term effect on patient compliance, but an uncertain long-term effect. Many physicians feel that they are the ones who should determine the extent of information given to patients.

81-1479
Evaluation of a Patient Education Manual.
Anderson, J. E.; Morrell, D. C.; Avery, A. J.; and Watkins, C. J.
British Medical Journal (London) 281(6245):924-926, October 4, 1980.

A randomized controlled trial involving 284 families from a group practice has demonstrated that families receiving a health education booklet describing management of six common symptoms had fewer consultations for those symptoms than control families. These symptoms were a stuffy or running nose, sore throat, cough, vomiting, diarrhea, and minor trauma. A subsequent study involving a random sample of 51 mothers from the original study group, followed up the original study by interviewing the mothers in their homes via a questionnaire designed to measure the mothers' knowledge of the management of the symptoms described. The interviews indicated that the booklet did not lead to any increase in the knowledge of the mothers receiving it. The questionnaire did show however that 76 percent of the mothers had consulted the booklet at some time during the year of the study, and 28 percent had consulted it in the 3 months preceding the interview. These findings may indicate that parents benefit more from a simple reference manual than from an educational program designed to increased their knowledge about the management of illness. 6 references.

81-1480
Telling the Patient.
Beahrs, O. H.
In: American Cancer Society Second National Conference on Human Values and Cancer; Chicago, Illinois, September 7-9, 1977; Proceedings. New York, American Cancer Society, p. 109-111, 1978.

Although physicians should always be truthful in informing cancer patients of their disease and prognosis, such disclosures should be tailored to the patients' needs. Before operations or treatment programs for cancer, long-term results should be discussed; this is particularly true when anatomic defects or alterations in bodily functions are expected. Numerous pamphlets are available to help the patient adjust to these changes. Educational interventions by specialized personnel, counseling by former patients, and inclusion of spouses and other family members in discussions of therapy will aid the patient during the preoperative period. Postoperative education and counseling should be as factual and positive as possible and should be repeated several times. Discussions should be conducted in lay terms and should include significant others in the patient's life. Before the patient's dismissal, instructions should be given about followup examinations and their frequency.

81-1481
The Reality of Epilepsy: An Up-to-Date Approach for Patients and Practitioners.
Beniak, J.; Miller, D.; and Blesi, K.
Journal of Practical Nursing 20(3):22-26, 38, March 1980.

Because nurses encounter epileptic patients in numerous settings, they should be able to educate patients and their families about the disorder. Besides providing general information about epilepsy and the types of seizures, the nurse should teach proper first aid techniques during and after a seizure, diagnostic procedures, and management of epilepsy. Specific teaching areas should include medications, basic health care, safety, and personal rights and responsibilities. Resources available to the nurse, the patient and the family, include such national organizations as the Epilepsy Foundation of America, the Training and Placement Service (TAPS), Services for Children with Handicaps, the State Vocational Rehabilitation Agency, and the Comprehensive Epilepsy Program (CEP). 7 references.

81-1482
Educating the Consumer: Patient Education and Preventive Medicine.
Berg, R. L.
Bulletin of the New York Academy of Medicine 57(1):80-86, January-February 1981.

Effective health education is hindered by the biomedical disease model and the physician's allegiance to this model. However, recent changes in physician-patient relations may help overcome the hinderance. Involvement on the

part of the patient in self-care and preventive practices can be facilitated by the physician who provides patients with instruction about their treatment. Physicians should know the attributes of the compliant patient and the noncompliant patient, and means of improving compliance through properly designed treatment regimens. An understanding of the value of the Health Belief Model and the patient's cultural background can assist the physician to determine a patient's response to a prescribed regimen. Patient-physician contracts have had marked success in increasing compliance. Team teaching and the use of other holistic health techniques also have been effective. Finally, the mass communication media offer an excellent channel for preventive health education. 6 references.

81-1483
Patient Education: RNs Do It Better Than MDs (Editorial).
Berger, D. W. and Carracino, T.
RN 43(12):91-92, 94, December 1980.

Physicians who believe that patients are sufficiently instructed without the help of nurses or patient educators must be unaware of the frequent returns to the intensive care unit of cardiac patients who have been inadequately instructed concerning medication, diet, and physical activity. Cardiac patients require indepth instruction in permitted activity levels, gradual return to full sexual functioning, medication regimens, and the reasons behind changes in lifestyle. Failure by physicians to address these topics results in poor patient compliance to prescribed regimens and the possibility of relapse.

81-1484
Through a Child's Eyes: A Selected List of Books and Articles to Help Children Deal with Hospitalization.
Bland, R.
Green Bay, Wis., Nicolet Federated Library System, 12 p., September 1980.

Annotated citations of books and articles written to help children deal with hospitalization are provided. The materials cited are designed for young children, grade-school students, older children and young adults, parents, and professionals. All materials listed are available from the Brown County Library Collection in Green Bay, Wisconsin.

81-1485
Nursing Care of the Patient With Cerebrovascular Disease.
Breitbach, W.
Journal of Practical Nursing 30(9):32-33, 39, September 1980.

Important advances have come in the treatment of cerebrovascular disease (CVD). Many stroke victims can now be rehabilitated to function up to prestroke levels. Patients with partial recoveries can learn to live with and compensate for their inabilities. Improvement is also possible for patients with other conditions resulting from CVD, such as vascular insufficiency. Much of this advance is due to technological and pharmaceutical breakthroughs, e.g., antiplatelet medication, cerebral vasodilators, and computerized axial tomography (CAT) scans. Long-term CVD management advances have resulted from attitude changes among health care professionals and in a shift in care responsibilities to patients and their families. Stroke education and prevention has further decreased the incidence of CVD's. Rehabilitation programs are an important part of treatment, with significant therapeutic advances in rehabilitation hospitals and patient therapy sessions at hospitals or in the home. CVD patients need much ongoing encouragement from the medical staff; family members must also be encouraged to participate. The long-term care involved in making a successful comeback is based on the patient's individual motivation. A helpful rehabilitation aid is the film "Stroke, Counterstroke."

81-1486
Changing Horizons: An Educational Program for Children with Diabetes.
Carney, N. K.
Diabetes Educator 5:11-16, Winter 1979-80.

The educational program of a week-long summer camp (Camp Ko-Man-She) for diabetic children is examined with emphasis on the nurse's role. The camp differs from the rigid hospital structure and control and from the often uncontrollable home and family life environment. Prior to the camping program, a staff orientation is conducted that consists of a film and discussions of medical aspects of diabetes, treatment at camp, diet routine, and activities. Camp participants attend daily informal group teaching sessions with a doctor, nurse, and dietician team. Pre- and posttests are administered at each session to evaluate group learning needs and teaching effectiveness. Session topics include exercise and activity; insulin administration, balancing insulin with diet and exercise, and adjusting dosage; dietary information, including individual help at meal and snack periods; how campers felt about their diabetes and the resulting responsibilities; and a group discussion on the final camp day for reinforcement. Suggestions for program usage in the hospital and home are given, and a list of resources for planning programs is appended. 13 references.

81-1487
Developing Education for Children with Asthma Through Study of Self-Management Behavior.
Clark, N. M.; Feldman, C. H.; Freudenberg, N.; Millman, E. J.; Wasilewski, Y.; and Valle, I.
Health Education Quarterly 7(4):278-297, Winter 1980.

A health education program to test the hypothesis that better family self-management of asthma can reduce the negative impact of the disease was developed by staff at the Columbia University College of Physicians and Surgeons using 300 low-income Hispanic and black families attending pediatric allergy clinics in New York City. Each family was randomly assigned to a control or experimental group; open-ended interviews with the first 100 families and administration of questionnaires to the first 202 families provided data for design of the educational intervention. Data were accumulated on a variety of topics concerning asthma self-management including health practices and beliefs, coping skills, asthma knowledge, and locus of control. An Asthma Self-Management Index was developed to measure positive management behaviors by the family. The needs assessment indicated that priority educational themes for the families included helping the child to take medicine, setting realistic limits for the child's activities, dealing with an asthma attack at home, getting information from the physician, keeping the child healthy, and helping the child do well in school. Educational sessions incorporating these themes are currently at different stages of operation at Harlem, St. Luke's, Roosevelt, and Presbyterian Hospitals in New York City. Evaluation procedures will begin at the conclusion of the educational program. 23 references.

81-1488
Counseling in Mastectomy.
Comfort, A.
In: Sexual Consequences of Disability. Comfort, A., ed. Philadelphia, Pa., George F. Stickley Co., p. 223-226, 1978.

Counseling patients who have undergone mastectomy procedures involves dealing with the psychic effects on the woman's body image, self-esteem, and sexual self-image. All women should be aware of the treatment alternatives long before the necessity arises to choose radical or conservative surgery or radiotherapy. Each patient should be provided with a written handout discussing breast cancer and these alternatives. In the event of breast cancer, the patient should be provided with psychotherapeutic assistance that includes the woman's male partner. Photographs of the long-term postoperative result, discussions with women who have undergone mastectomies, provision of early and practical counseling, and discussions of future dating and sexual activity will forestall extreme reactions. Discussion of possible male reactions are crucial during counseling. Every radical breast surgery procedure should be undertaken with a full program of personal and sexual rehabilitation.

81-1489
Educating Patients About Their Medication.
Corlett, P. A.
Nephrology Nurse 2(5):10-11, September-October 1980.

Because a survey of renal patients indicated that patient compliance to prescribed drug regimens was poor, a nephrology nurse developed a written medication schedule, special drug labels, and a booklet on drug therapy to reinforce compliance. Patients were requested to bring in their medication bottles and to answer, with their families, questions about medication therapy. Kardex-type schedules were used to provide an easy-to-read and accurate record of each patient's medication. The new drug labels provided both generic and trade names for the medications. A physician and a nurse taught each patient and the patient's family about the effects and functions of pertinent drugs. The book reinforced this educational intervention. A quiz given to 15 families indicated that the program was successful in achieving its goal of increasing the understanding of the drug regimen by patients and their families. 3 references.

81-1490
Helping Expectant Parents Understand the Fetal Monitor.
Cupit, L.
Pediatric Nursing 6(3):21-23, May-June 1980.

An educational model for teaching expectant parents about the use of fetal monitors has been developed to help nurses decrease parental anxiety associated with use of the device. The monitor picks up physiological information about the baby's heart rate and the mother's uterine contractions. Application of the monitor may be internal or external. Lamaze couples have found the monitor particularly helpful in managing their labors. Women can use monitor information to help them prepare for contractions and to be ready to initiate their breathing techniques.

81-1491
Diabetes Teaching: A Close-Up.
Dries, L. and Dizzia, S.
Diabetes Educator 6(4):26-29, Winter 1980-81.

Since diabetics often lack sufficient self-care knowledge, a program involving 53 hospitalized diabetic patients emphasized a multidisciplinary teaching approach. Subjects were selected after review by representatives from the departments of nursing, pharmacy, dietetics, and management engineering. The 21 men and 32 women were 15 to 65 years old. The patients were taught individually by nurses, dieticians, and pharmacists. Teaching aids used included flip charts, closed-circuit television, pamphlets, and tape presentations. Patient knowledge was assessed before and after educational intervention via a questionnaire containing 22 open-ended questions. Questionnaire results indicated that (1) patients understood diet and insulin regimens prior to the program, but did not understand urine testing or the proper time to contact their physicians; (2) the program improved knowledge in areas in which the patient had insufficient knowledge; (3) the program did not significantly increase patients' understanding of the symptoms of hyperglycemia; (4) age correlated negatively with postprogram scores; and (5) patients who controlled their diabetes via insulin scored higher than those who controlled their diabetes via diet or oral hypoglycemics. Individualized teaching and active patient participation were the program's two strongest points. 3 references.

81-1492
Directory of Health and Patient Education Programs in North Dakota.
Eisenzimmer, M.
Bismarck, N. D., North Dakota State Department of Health, Division of Health Education, 159 p., 1980.

A directory of health and patient education programs in North Dakota is provided to help identify health and patient education programs in the State, facilitate the sharing of materials among programs, and to build a network of contact people and resources. Programs listed include those that address alcohol and drug abuse, cardiac and coronary care, child care and safety, control of cholesterol levels, diabetes, emergency medical training, family planning, nutrition, first aid, glaucoma, hypertension, hysterectomy, infant care, Lamaze birth methods, low salt diets, parenting, prenatal care, psychiatric needs, smoking cessation, special diets, stress control, triglyceride control, ulcers, vocational adjustment, and weight control. The listings are arranged by county and indexed by subject.

81-1493
The Swedish Back School.
Forssell, M. Z.
Physiotherapy (London) 66(4):112-114, April 1980.

The program of the Swedish Back School developed at Danderyd Hospital in 1970 consists of four 45-minute lessons supervised by a physiotherapist. Six to eight patients participate in each course, which is spread over a 2-week period. A third of each session consists of an audiovisual presentation, and the remainder of the session involves the use of a plastic skeleton, flip charts, and other practical aids. The first lesson includes a summary of the entire course, instruction in the anatomy and function of the back, discussions of treatment methods, and the importance of the semi-Fowler or psoas relaxation position. During the second lesson, the mechanical strain in different positions and during different movements is discussed, the relationship between the center of gravity and strain on the back is explained, the function of the muscles and their influence on the back is demonstrated, and instruction in isometric abdominal muscle training is provided. The third lesson involves practical application of previously acquired knowledge, with special attention devoted to lifting and carrying methods. The fourth lesson consists mainly of encouraging the patients to increase their level of physical activity. A questionnaire survey of 140 patients who had completed the course over a 7.25-year period indicated that 75 percent of the subjects applied exercise principles learned during the course. Another study carried out in an occupational setting indicated that the Swedish technique combined with physiotherapy was more effective than a placebo technique.

81-1494
Teaching Patients About Adrenal Corticosteroids.
Gotch, P. M.
American Journal of Nursing 81(1):78-81, January 1981.

Long-term administration of oral adrenal corticosteroids may be prescribed for a variety of pathological conditions when an individual's body cannot produce enough cortisol. Nursing management of any patient taking corticosteroids focuses on safe medication education. The nurse must be familiar with basic adrenocortical physiology; a patient on oral corticosteroids should be able to state the name, dosage, and basic therapeutic action of the prescribed corticosteroid. Serum cortisone levels fluctuate in diurnal cycles, requiring patient awareness that medication should proceed at the same time daily. Correct medication helps to reduce side effects; the medication should never be stopped abruptly. The patient should be advised to avoid all exposure to stress, as large doses of adrenal corticosteroids suppress the body's ability to mobilize many aspects of the immune response system. Patients should also be instructed in proper diet, avoidance of stimulants, symptoms of adrenal insufficiency, and reporting of abnormal side effects. Education of the patient on

long-term corticosteroids is highly individualized and must be planned in collaboration with the patient's physician. Emotional support is essential. The nurse is challenged to educate patients to assume a high level of self-care without discouraging them with the undesirable effects of therapy. 6 references.

81-1495
The Professional and Scientific Literature on Patient Education: A Guide to Information Sources.
Green, L. W. and Kansler, C. G.
Detroit, Mich., Gale (Health Affairs Information Guide Series, Vol. 5, 330 p, 1980.

Annotations of professional and scientific literature of the mid-1970's on patient education are provided. Subjects covered include history and organization of the field of patient education; organization of concepts in the field; health problem analysis; behavioral problem analysis; factors predisposing, enabling, and reinforcing patient behavior; communications theory and practice; organizational theory and methods for patient education; staff development and administration; and research and evaluation methods. Lists identifying agencies, institutions, and companies who produce educational materials or provide other forms of assistance in relation to health education; a compilation or private, federal, and commercial newsletters that cover national health activity; and a list of accredited schools of public health whose faculty members provide consultation on patient education are appended.

81-1496
The Canadian Back Education Units.
Hall, H.
Physiotherapy (London) 66(4):115-117, April 1980.

The Canadian Back Education Units were developed to free the orthopedic surgeon from repeating the same basic message to every patient. Currently the units are provided at 11 Toronto-based programs, 8 programs elsewhere in Canada, and 2 programs in the United States. Four physiotherapists visit every unit periodically to monitor the presentations and discuss problems with the unit head. The typical hospital-based program consists of four 90-minute lectures held at weekly intervals for classes of 15 to 20 people. The sessions are successively team taught by an orthopedic surgeon, a physiotherapist, a psychiatrist, and a psychologist. The sessions address anatomy and physiology of the back, the role of exercise, emotional influences on low-back pain, and relaxation exercises. A review class is provided 6 months after each original series. Individual physiotherapy is conducted independently of the lectures. The program costs $30 per participant. A study of heights, weights, and ages of almost 4,000 participants is being completed, and computer storage and analysis of data will allow assessment of a broad range of participant characteristics. A questionnaire has been developed to assess subjective evaluation of patients concerning their back pain before and after the program.

81-1497
Counseling the Person With Cancer.
Hamilton, P. K., Jr.
In: American Cancer Society Second National Conference on Human Values and Cancer; Chicago, Illinois, September 7-9, 1977; Proceedings. New York, American Cancer Society, p. 154-159, 1978.

The physician must develop an ability to inculcate hope into the life of the cancer patient. This requires constant assessment of the patient's body language and conversation. A trusting relationship must be developed between patient and physician if the former is to muster the requisite emotional strength to deal with the rigors of treatment. An effective counseling and health care team should include clinic staff, family members, and volunteer aides. Though the side effects of treatment must be explained, explanations should be accompanied by a sympathetic outline of the benefits of treatment. Inclusion of family members at patient education sessions and on educational forums ensures their cooperation in treatment. Patients should be encouraged to return to normal activities as soon as possible. Self-help programs have found biofeedback and relaxation training extremely effective, and several good manuals are available to help the patient return to normal functioning. 3 references.

81-1498
Developing Drug Information for Patients.
Hecht, A.
FDA Consumer 11(7):16-19, September 1977.

The Food and Drug Administration (FDA) has mounted a massive effort to assess the public's need for information about drugs in terms of patient package inserts (PPI's). Since late 1974, the FDA has been gathering information through meetings and discussions with medical, pharmaceutical, and consumer groups. A survey has been made of users of oral contraceptives, one of the four prescription drugs for which PPI's are now required. A controlled study is underway to determine whether information about prescribed medication will make a difference in patients' knowledge and attitudes about their treatment. Data from consumer surveys and letters in re-

sponse to a petition by a consumer group indicated that consumers favor PPI's. Health professionals have been divided over whether to endorse or oppose the use of PPI's. Some professionals feel that it will leave the field open to quacks, interfere with the physician-patient relationship, increase the cost of drugs, and confuse patients. Many professionals are concerned about the amount of information in the PPI's. The American Medical Association, the Pharmaceutical Manufacturers Association, the American Society of Hospital Pharmacists, and the American Pharmaceutical Association all favor PPI's for drugs, but diverse opinions are held on the content of PPI's. The FDA plans to develop a systematic means of designing PPI's to answer the needs of consumers and professionals.

81-1499
Pharmacist Involvement in Home Parenteral Nutrition Programs.
Karnack, C. M.; Gallina, J. N.; and Jeffrey, L. P.
American Journal of Hospital Pharmacy 38(2):215-217, February 1981.

A national survey of hospital-based home parenteral nutrition (HPN) programs was conducted in 1979, by mailing questionnaires to 70 hospitals. HPN refers to the intravenous administration of essential nutrients to the patient in the home, rather than the hospital. The questionnaires, which were sent to each hospital's department of pharmacy, consisted of a series of statements to be checked by program staff if applicable to the program. Data from the 51 respondents indicated that the "typical" hospital providing HPN services was a private, nonprofit, university-affiliated teaching hospital with more than 400 beds. HPN programs had been in operation for a mean of 3 years; most programs served two patients or less. Hospital pharmacies prepared the nutrition solutions 57 percent of the time; 25 percent of the programs required preparation of the fluids at home. Most HPN programs had patient education and training activities. Pharmacists and physicians were most commonly responsible for monitoring patients' laboratory results. Most HPN programs (90 percent) were reimbursed for solutions and supplies, but only 20 percent were reimbursed for patient education services. 16 references.

81-1500
An Australian Programme for Management of Back Problems.
Kennedy, B.
Physiotherapy (London) 66(4):108-111, April 1980.

The Australian back management program, which focuses on the abdominal bracing method, is an eight-step program that begins with a thorough assessment of the patient and development of an individualized treatment plan. The program includes an explanation of the functional pattern of back movements, discussion of efficient body alignment, instruction in dynamic abdominal bracing, instruction in relaxation and breathing techniques, demonstration of proper sitting and lying postures, demonstration of procedures to relieve pain, instruction in means of restoring muscle function, and instruction in mobilization of tight structures. A double-bind controlled trial designed to assess the efficacy of the program indicated that exercises using the program's intra-abdominal pressure mechanism for patients with back pain were more effective than back extension exercises and mobilization exercises. The program has been invaluable in teaching more than 4,000 patients how to stay within their limitations, while gradually widening their field of activity. 16 references.

81-1501
Diabetic Day. Setting Goals for a Child-Directed Ambulatory Program.
Kohler, E.
Clinical Pediatrics 17(1):24-28, January 1978.

A program called Diabetic Day for the care and education of diabetic children has been offered for the past 50 years at Milwaukee Children's Hospital. The program serves 64 boys and 60 girls, 5 to 18 years old. Children come to Diabetic Day every 3 months in age- and sex-appropriate groups of 6 to 10 children. Activities include assessment of blood-sugar levels and insulin administration technique, educational and discussion sessions that rely heavily on peer support, play activities, individual discussion of home management schemes, clinical examinations, assessment for kidney damage, blood tests, nerve conduction assessments, and ophthalmologic examinations. The general goals of Diabetic Day are self-care, health maintenance, and development of full living capacity. A multidisciplinary health team works through the day-long ambulatory program to teach the skills of self-care to the children and endeavors to provide optimal health maintenance with the aid of appropriate clinical and laboratory evaluations. These efforts along with appropriate social and psychological approaches are expected to allow children with juvenile diabetes to achieve their ultimate goal of living to capacity. 7 references.

81-1502
The Practice Brochure: A Patient's Guide to Team Care.
Marsh, G. N.
British Medical Journal (London) 281(6242):730-732, September 13, 1980.

A practice brochure describing the primary health care team was given to 262 newly registered and 253 established female patients in a group practice to determine whether the literature would result in greater awareness and more efficient use of the staff and facilities of the practice. The women were 18 to 55 years old. Half of each group was given brochures. All subjects were interviewed in their homes by one of three interviewers 2 to 3 weeks after the distribution of the brochures. The interviews were structured to determine perceptions of the brochure, knowledge of the team members, and ability to deal with certain health problems. Of the 258 patients given the brochure, 30 had not read it. Ninety-eight percent of those who had read the brochures found no difficulty in understanding it and 89 percent enjoyed it. Most of the patients favored the cartoon illustrations. Most of the new and a majority of the established patients claimed that the book provided them with new information. Patients who had read the brochure were more likely to consult a nurse than a doctor for a medical problem or for a routine medical intervention. Hence, it appears that such a brochure can enhance the patient's appreciation for the medical practice and increase efficient use of the medical care team.

81-1503
The Genetics of Diabetes: Nursing Roles and Responsibilities.
Matthews, A. L.
Diabetes Educator 6(4):30-33, Winter 1980-81.

A review of the genetics of diabetes and of the process of genetic counseling provides the nurse educator with an understanding of the roles and responsibilities of the diabetes counselor. The disease results from a complex interaction of genetic and environmental factors, precluding a simple Mendelian pattern of inheritance. Hereditary factors seem to be polygenic with a familial pattern of inheritance. The two types of diabetes are maturity-onset or noninsulin-dependent diabetes and juvenile onset or insulin-dependent diabetes, each of which has a unique etiology. Considerable research is now being conducted to investigate the relationship of diabetes and the histocompatibility antigens. Congenital malformations in infants of diabetic mothers are two to four times greater than those seen in nondiabetic pregnancies. In the area of genetic counseling, the diabetic counselor should initiate a complete family history, review family medical records, explain the counseling procedure to the family, and follow up the counseling experience to ensure that no misconceptions have been formed. 14 references.

81-1504
The California Back School.
Mattmiller, A. W.
Physiotherapy (London) 66(4):118-121, April 1980.

In San Francisco, California, a model school was developed in 1976 to educate patients with back problems. The school program involves three 90-minute visits over a 3-week period with a followup visit 1 month after the end of the program. Each class includes a 15-minute lecture on theory, a 15-minute audiovisual presentation, and a 60-minute session of individual assessment and practical application of the theory. Patients are assessed and interviewed by a physiotherapist on each visit to the school. In addition to patient assessment, various educational tasks are scheduled during the three visits. The first visit includes an obstacle course test, an exercise tolerance test, an educational session, and individualized reviews of work activities. The second visit includes a discussion of daily activities, a coordination exercise period, and instruction in home program exercises and back protection at work. The third visit includes instruction in load handling and sports activities. Space restrictions limit class membership to four persons, but individualized instruction can be arranged. At the followup visit, the [illegible] quizzes patients on course fundamentals, and evaluates their ability on the obstacle course, exercise proficiency, and general progress. A 2-year study of the first 300 students indicated that 95.4 percent had achieved acceptable pain levels and that 64 percent had not changed jobs during the study. 7 references.

81-1505
A Study of the Difference in Health Knowledge Gained Through Formal and Informal Teaching.
Milazzo, V.
Heart and Lung 9(6):1079-1082, November-December 1980.

An experimental, three-group, pre- and posttest study involving twenty-five 35- to 65-year-old coronary patients was designed to determine the effects of formal versus informal teaching on the knowledge of patients. One experimental group was given a slide presentation and the other experimental group was given the slide presentation and then administered the posttest evaluation instrument

without having been administered the pretest instrument. A control group received informal teaching only. The slide presentation lasted approximately 45 minutes and was presented to each patient individually. The pre- and post-test instrument consisted of 20 multiple-choice items on heart disease. Nonparametric statistics were used to determine if there was a significant difference across groups. The experimental group that was administered an evaluation instrument before and after the intervention demonstrated a significant increase in knowledge when compared to the control group. This result suggests the need for formal, standardized patient teaching programs based on adult learning therapy and implemented by nurses and other health care professionals. 9 references.

81-1506
Selected Bibliography on Patient Education.
National Heart, Lung, and Blood Inst. (DHHS, NIH), Bethesda, High Blood Pressure Information Center.
Bethesda, Md., the Center, (NIH Publication No. 81-2203), 24 p., November 1980.

Selected references on patient education are provided for the health care team and individual practitioners. Citations concerning patient education literature are provided for program conceptualization; methodology; instructional resources; hospital, emergency room, ambulatory care, community, and workplace settings; team care approaches; roles of the physician, nurse, dentist, allied health professionals, and health educator; reimbursement and financial considerations; patients' rights and ethics; compliance; hypertension control; and evaluation.

81-1507
To Improve Patient Adherence to Drug Regimens: An Interdisciplinary Approach.
Romankiewicz, J. A.; Gotz, V.; Capelli, A.; and Carlin, H. S.
American Journal of Nursing 78(7):1216-1219, July 1978.

The medical patient care committee, a subcommittee of the medical board of the New York Hospital, has developed a multidisciplinary program of discharge teaching to help patients comply with prescribed regimens. The subcommittee includes representatives from the medical, nursing, pharmacy, and social services departments as well as from the hospital administration. As part of the program, the drug information service of the pharmacy developed patient medication instruction cards for individual therapeutic agents. Members of the medical board's formulary and therapeutics committee reviewed the cards with members of the pertinent departments. Resulting minor editorial changes were incorporated into the wallet-size cards. The cards offer information on the rationale for prescribing the drug, precautions that should be taken by users, adverse effects that should be reported, and specific information regarding topics such as administration of the drug. The cards use only lay terminology. The pharmacy distributes the cards along with medications when patients are discharged or when clinic prescriptions are filled by outpatients. Inservice training on the use of the cards was provided for nursing staff. Information identical to that on the cards is provided on loose-leaf sheets for use by nurses and pharmacists in counseling patients while the latter are being hospitalized. A formal evaluation indicated that the cards and associated programming was effective. 23 references.

81-1508
Diabetic Education.
Rose, V.
Nursing Times (London) 74(10):388, March 9, 1978.

A 22-bed hospital in Denmark has instituted a teaching program for diabetics to help them understand, acknowledge, and accept their disease. Ninety percent of the patients at the hospital are diabetics. The program emphasized family involvement and used teaching aids to illustrate the pathology and physiology of the disease. Health visitors teach patients who live near the hospital in the patient's own homes. The nurse is the central figure in the program. A physician from Holland discussed the effectiveness of deliberately induced hypoglycemia as a means of preventing recurrent hypoglycemia caused by patient ignorance. After inducing hypoglycemia in 30 patients through controlled doses of soluble insulin, the patients were asked to write a description of their feelings as the attack progressed. Results of this intervention have been encouraging.

81-1509
Education, Screening, and Genetic Counselling in Thalassaemia (Letter).
Rossiter, M. A.; Solomon, M.; Marsh, G. W.; Reeve, J. D.; and Peckham, C. S.
British Medical Journal (London) 281(6241):678-679, September 6, 1980.

In 1977, hemoglobinopathy screening was offered to eighty-four 14-year-old London children at a school containing ethnic populations that are at-risk for thalassemia. Of the 63 children that presented themselves for screening, 15 were suspected of having hemoglobinopathy and 12 were confirmed to have it. The 15 children and their

families were offered two counseling sessions at 1-month intervals. Six months later, structured questionnaires were submitted to the families. Only six families returned the questionnaires. These numbers were too small to result in significant findings. Nevertheless, the results indicated that (1) although the children could understand the counseling, their families had difficulty in this area; (2) the extreme variety of hemoglobinopathic traits made counseling extremely difficult; and (3) the families found it impossible to accept the concept of a healthy carrier. Rather than mounting a mass screening campaign for hemoglobinopathy, health education combined with financial support for hospitals offering testing and counseling should be undertaken.

81-1510
Patient Compliance: The Effect of the Doctor as a Therapeutic Agent.
Schmidt, D. D.
Journal of Family Practice 4(5):853-856, May 1977

A review of patient compliance research data focuses on features associated with compliance that are clinically relevant for the practicing physician. The key features include the intelligence of the patient, the patient's knowledge of the disease, the complexity of the medical regimen, the influence of the family, the doctor-patient relationship, the patient's perceived susceptibility to disease and the patient's perception of the severity of the disease. Recommendations are presented to enhance patient compliance and enable physicians to be more effective as therapeutic agents. The physician should remember that (1) an intelligent, upper-class patient is not always a compliant patient; (2) patients who insist that they are following physician's orders are occasionally noncompliant; (3) experienced patients require relatively frequent reinforcement; (4) complex regimens should be avoided or meticulously outlined; (5) family members should be involved in patient education; (6) socially disorganized families require additional attention; (7) the seriousness of an illness should not be minimized during patient education; (8) the negative effects of noncompliance should be emphasized; (9) educational intervention should be provided throughout treatment; (10) tension between the patient and the physician should be minimized; and (11) the patient's self-esteem should be bolstered whenever possible. 28 references.

81-1511
Recommended Action Responds to Local Needs and Resources.
Shanahan, M.
QRB. Quality Review Bulletin Spec. No.:57-59, 1978.

Nursing audits of diabetes mellitus using similar discharge status criteria uncovered numerous deficiencies in patient education at two separate hospitals. Teaching skills of staff members needed improvement, and patient education programs for diabetes management required revision. The audit criteria identified problems and causes and suggested action plans. Actions recommended that more written standards for diabetes education be placed on all patient care units and the nursing staffs be informed of the discovered lack of documentation of patient education. Recognized deficiencies included lack of skills for patient teaching, absence of structured approach to diabetic education for both nurses and physicians, poor acceptance of independent nursing action, insufficient specialized nursing personnel and education resources, language barriers, and cultural distinctions. At one institution workshops were instituted to improve teaching skills; audits were performed 3 weeks later. At another institution a standard patient-family teaching manual was compiled. A separate action plan was drawn up for the dietitians who instruct patients in dietary management.

81-1512
Teaching Your Diabetic Patient.
Sheeran, J.
Journal of Practical Nursing 30(1):22, 35-36, January 1980.

The diabetic patient should be educated regarding the disease and its management as soon as possible after diagnosis. If education is delayed, the patient may develop defense mechanisms that could make future teaching difficult. A close rapport should be established between the patient and the nurse educator; the family should be included in the educational process. Topics conducive to group sessions include hypergylcemia, hypoglycemia, urine analysis, sick day rules, and complications. The patient's ability to assimilate the information will depend upon the severity of disease onset, the patient's ability to develop new lifestyles, the type of treatment to be undertaken, the degree and extent of complications, the patient's ability to self-administer insulin, and the patient's role in life. Juvenile onset diabetics differ from adult onset diabetics in each of these categories.

81-1513
The Assistant as Preventive Dentistry Advocate.
Simon, W. J.
Dental Survey 55(9):45-53, September 1979.

The dental assistant is the logical dental team member to teach patients proper oral hygiene. After establishing a

relationship with the patient by asking about the frequency of, proper time for, rationale behind, and means of brushing, the assistant should use visual aids to teach oral hygiene principles and techniques. Films, flip charts, and typodonts are effective teaching aids, although the latter are often distracting. The assistant should also lead the patient through an actual brushing exercise in front of a mirror. The dentist should provide the assistant with information concerning types of brushes, dentifrices, and other dental care items so the assistant can pass this information on to the patient. Finally, the assistant should follow up educational interventions during subsequent visits. In addition to questioning the patient and providing brushing exercises, the assistant should apply disclosing solution to reveal areas missed and review brushing techniques.

81-1514
Patient Education--Is the Public Being Served? (Editorial).
Small, W. E.
American Pharmacy 20(11):2, November 1980.

The Food and Drug Administration's (FDA's) Patient Package Insert (PPI) program neglects and undermines the role of the pharmacist as a major source of patient education. Survey data used by the FDA to rationalize the development of PPI's and mandated patient education have been extremely sketchy. Pharmacists have tried to make the FDA and the public aware of the dangers of mandating patient education, including the costs of distributing PPI's, the dangers of patient noncompliance with prescribed drug therapy, the failure of patients to understand the printed information, and misinformation generated by those who have inadequate knowledge and background. Finally, the upcoming decade is likely to witness a movement of pharmacists into the areas of profile maintenance, drug monitoring, and patient education.

81-1515
ICBM--A Solution to the Problem of Informed Consent.
Stillman, R. M.; Cohen, D.; Mitchell, W. G.; Shaftan, G. W.; and Kountz, S. L.
Journal of Clinical Engineering 2(2):127-132, April-June 1977.

An individualized preoperative consent form has been developed by the Department of Surgery at the State University of New York at Brooklyn through an on-line computer interaction system called informed consent by machine (ICBM). Physicians program a structured series of questions and answers for different types of surgery and allow the patient to decide how much he wishes to learn about the operation. The correct responses to these detailed queries, explanations concerning incorrect responses, and choices for neutral questions concerning desired level of understanding combine to produce individualized consent forms that provide evidence of the patient's comprehension while providing preoperative education. Use of the computer program involves connection of a video screen data terminal and printer via telephone lines to a computer. The computer is available 24 hours a day for access to the ICBM routines stored in the memory of the machine. The physician activates the terminal and identifies the patient, surgeon, and nature of the operation to the computer. This procedure initiates a series of multiple choice questions that appear on the screen. The patient responds to each question and is provided with the next question if the correct answer is given or with a detailed explanation of the correct answer if the answer given is incorrect. Once all items have been answered correctly, a consent form is printed and signed by the patient. A sample program is appended. 10 references.

81-1516
Do Patients Read Breast Self-Examination Booklets?
Turner, J.; Blaney, R.; Irwin, G.; Odling-Smee, W.; and Roy, D.
Health Education Journal (London) 40(1):11-13, 1981.

A study involving 303 women patients of a 6-doctor practice in a country town outside Belfast was designed to ascertain whether the patients would read an explanatory booklet on breast self-examination (BSE) and whether reading the booklet would induce them to perform BSE regularly. The subjects constituted a random sample of 2,130 patients born between 1909 and 1952. A booklet on BSE accompanied by a cover letter was sent to the subjects. Two months later a researcher visited the patients and interviewed them with the aid of a questionnaire. A second group of 303 women, chosen randomly from the 2,130-patient pool, served as controls and did not receive the booklet. However, women in both groups were exposed to current public cancer education programs promoted through the media. Of those who had received the booklet, only 9.4 percent said that they did not read it. Of those who had read it, 44 percent had done so on 2 or more occasions, and 51.2 percent found the book fairly easy to understand. When shown the book at the end of the interview, only 29.2 percent of the control subjects found it easy to understand. Over 90 percent of the women in both groups approved of the program and its origin. The proportion of women in the experimental group who performed BSE rose from 57 percent before

the program to 89 percent after the program. A future study involving 30,000 subjects will be undertaken to determine the effect of the booklet on the rate at which lumps are reported. 2 references.

PROFESSIONAL EDUCATION AND TRAINING

81-1517
Health Materials for the Non-Medical Library: A Selected Bibliography.
Lang, L.
Cleveland, Ohio, Cleveland Area Metropolitan Library System, 19 p., November 1978.
Available from: Cleveland Area Metropolitan Library System, 11,000 Euclid Avenue, Cleveland, OH 44106.

Annotated citations of selected health materials are provided for reference librarians employed by a nonmedical library. Topics include accupressure, aging, anatomy, arthritis, bibliographies, cancer, child health, childbirth, consumerism, dentistry, diagnosis, dictionaries, directories, encyclopedias, exercise, optics, first aid, gastroenterology, genetics, gynecology, heart disease, hypertension, indexes and journals, medical examination, medicine, mental health, migraine headaches, nutrition and dietetics, occupational health, orthopedics, pain, pharmacology, poisoning, psychiatry, self-care, skin and hair care, smoking, stress, stroke, surgery, virus diseases, and vitamins.

81-1518
Theory and Practice in Health Education.
Ross, H. S. and Mico, P. R.
Palo Alto, Calif., Mayfield, 338 p., 1980.

A textbook of theory and practice in the field of professional health education is presented for use by undergraduate students. Topics include the definition of health education, the need for health education, problems in individual health behavior, theories of individual behavior, programs for individual change, problems in organizational behavior, problems in social health behavior, theories of social behavior, programs in social health education, planning for health education, methods for health education, evaluation of health education, and guidelines for professional health educators. Discussions of the functions of the health education specialist and of health education resources are appended. Glossary and numerous references.

81-1519
The Need to Improve Diabetes Education Programs.
Whitman, N. A.
Diabetes Educator 7(1):21-23, Spring 1981.

In 1977, the National Institutes of Health funded the Michael Reese Hospital and Medical Center and the University of Chicago Pritzker School of Medicine to develop a Diabetes Research and Training Center (DRTC). The goal of DRTC is to design, implement, and evaluate teaching methods for training and updating practitioners in the care of diabetic patients. In April 1980, DRTC educators focused on the need for a curriculum to address the coordination of a diabetes education program in community hospitals and other institutions. A needs assessment survey was mailed to 73 hospitals listed as members of the Northern Illinois Affiliate of the American Diabetes Association and 49 hospitals listed as members of the Chicago Hospital Council. The 47 responses indicated that all but four hospitals had diabetes education programs, indicating the need for improvement rather than initiation of programming. Respondents were most interested in developing staff teaching skills, obtaining administrative and staff support, evaluating programming, boosting patient attendance, and dealing with competing patient teaching priorities. Curriculum planners also interviewed diabetes educators at eight hospitals to obtain qualitative data. As a result of the survey and the interviews, an assessment manual was developed that allowed hospital coordinators to determine their needs in preparation for a workshop. A pilot workshop has been scheduled for the fall of 1980.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-1520
Growing Pains.
Burningham, S.
Health and Social Service Journal (London) 88(4607):1010-1012, September 8, 1978.

Since the reorganization of the National Health Service in Great Britain, the role of the health officer has changed dramatically. Lack of team work prevents the system from achieving its full capability, and it is flawed by an uneven distribution of health officers, leaving 17 area health authorities without an officer. No minimum entry requirements for health education officers exist and there is no independent training board. Some officers would like to

see a certificate program instituted. The Guild of Health Education Officers and the Association of Area Health Education Officers can be helpful in instituting this program. The Greenwich and Bexley Authority has one of the few highly developed teams in the country, a team that includes two senior and five basic officers, five technicians, and two clerical staff. The team provides courses for health educators, encourages schools to adopt health education curricula, and provides inservice training in health education for teachers. An optimal team would comprise 14 members who could respond to the unique needs of the community. Larger teams can employ personnel for research and experimentation.

81-1521
Three Types of Health Education (Letter).
Catford, J. and Dillow, I. A. P.
British Medical Journal (London) 281(6242):744-745, September 13, 1980.

A multidisciplinary regionwide health team was formed on an experimental basis in Wessex, England, to investigate the effectiveness of "personal" health education (emphasizing individual and collective responsibility for good health). A disappointing community response to this approach indicates a need for a "social" health education program that promotes legislation to insure a healthful environment. Such an approach includes promotion of legislation to insure a healthful environment.

81-1522
Three Types of Health Education.
Draper, P.; Griffiths, J.; Dennis, J.; and Popay, J.
British Medical Journal (London) 281(6238):493-495, August 16, 1980.

Of the three types of health education, namely provision of hygienic advice, information about health services, and public health education, the last has been sadly neglected. Public health education is relevant to a wide range of policies in which health issues are currently given scant regard. Agriculture, food, and transportation are areas in which health educators can advocate changes that will promote good health. The dependence of the government and the press on revenues from the tobacco industry is a blatant example of the adverse health consequences of pursuing indiscriminate economic growth. The adverse consequences of unemployment and damaging employment (i.e., work involving exposure to chemicals or unsafe machines) provide another example. National associations of health professionals and other groups have the greatest power in altering public policies that contribute to these problems. The community development approach taken by developing countries and the American "war on poverty" in the 1960's have provided models for community interventions by local health educators. Finally, it must be remembered that public health is a social change movement based on an ecological approach and that it tends to be opposed to conservative forces. Hence, it is likely to be opposed by those with political and financial power. 15 references.

81-1523
The Science and Politics of Nutrition Education.
Gussow, J. D.
Journal of Nutrition Education 12(3):140-148, July-September 1980.

Those who complain that advocates of nutrition education are allowing their scientific goals to give way to political goals misunderstand the fact that science cannot be apolitical. When competing for scarce resources, making decisions about the value of current and future food-processing techniques, or regulating advertising of food products directed at children, political choices must be made and political power wielded. Arguments in the nutrition profession are not over the data, but over the meaning of the data and the conclusions drawn. Complicating the normal political struggles over these issues is the fighting among nutritionists who support, or purportedly support, one nutrition regimen over another. Finally, the fear of being labelled unscientific forces many nutrition advocates to take political stands that contradict their political philosophies.

81-1524
Legislative Advocacy in Health Education: A Case Study.
Henderson, A. C. and Cortese, P. A.
Health Education 12(2):25-27, March-April 1981.

Health educators in California have proven effective in legislative advocacy for new and different health education programs. After numerous failures with the State legislature and the Commission for Teacher Preparation and Licensing (CTPL) during the early 1970's, a communication network was established among persons interested in establishing compulsory school health education and requiring credentials of health educators. After several meetings, a committee of Concerned Professors of Health Science was created to gain support from various educational and political groups. In August 1975, legislation was introduced to establish a health science and safety studies credential. With the help of the California School Health

Association, members of the CTPL were convinced to change their position on the credentials issue from negative to neutral. Through the lobbying efforts of professional and student health educators the bill passed. Although the governor vetoed the bill, the success of the lobbying effort indicates the value of continuously informing legislators and agency policymakers, obtaining grass roots support, contacting legislators in their home districts, and persisting in contacts with all persons that can affect a bill. 2 references.

81-1525
Health Promotion--An Idea Whose Time Has Come.
Nassif, J.
American Lung Association Bulletin 66(7):8-12, September 1980.

Today's health problems differ from former ones and demand new strategies. National health gains have been realized largely through control of infectious and communicable diseases through implementation of public health measures. Nevertheless, the Surgeon General reports that 7 out of 10 current leading causes of death in the United States could be reduced through behavior changes among high-risk individuals. Also, high-risk individuals are often high-cost users of medical services, thereby affecting overall health costs. Behavior changes in nutrition, stress management, smoking cessation, alcohol and drug abuse reduction, and accident prevention form the framework of health promotion and maintenance. Individual self-responsibility for health, changes in the environment, and appreciation of the interrelatedness of all health aspects are also critical to well-being. Health promotion activities are spearheaded at the Federal level by the Office of Health Information, Health Promotion, and Physical Fitness and Sports Medicine (OHP). The 1979 federally sponsored Regional Forums for Community Health focused on grass-roots organizing, and the American Hospital Association and the American Lung Association concentrated on private-sector efforts. 1 reference.

RESEARCH AND EVALUATION

81-1526
The Impact of Providing Physicians with Quit-Smoking Materials for Smoking Patients.
CA 31(2):75-78, March-April 1981.

A survey of 175 general practitioners, 143 internists, 125 obstetricians-gynecologists, and 51 physicians with miscellaneous specialities was designed to determine whether provision of materials developed to help consumers quit smoking would stimulate physicians to play a stronger role in smoking cessation activities. The materials included a pamphlet that described methods to break the smoking habit and a kit that contained a poster, a waiting room sign, a desk-top sign, and smoker stickers to be placed on the records of patients who smoked. The survey involved physicians in California, Delaware, Georgia, Pennsylvania, Rhode Island, and Wisconsin. The subjects were divided into four groups, including one group that was given the kit, one group that was given the pamphlet, one group that was given both, and a control group. Four weeks after distributing the materials, all 494 physicians were contacted via telephone to determine the nature of their interactions with smoking patients. Results of the interviews indicated that the materials fostered greater physician effort to persuade their smoking patients to quit smoking, increased the number of physicians who spoke to their patients about quitting smoking, and helped make physicians more comfortable in speaking to smokers. Those physicians who received both types of materials responded better than any other group.

81-1527
Radio Campaigns and Family Planning in Colombia, 1971-1974.
Bailey, J. and Cabrera, E.
Bulletin of the Pan American Health Organization 14(2):126-134, 1980.

Between 1971 and 1974, three similar radio campaigns were undertaken in Colombian cities to encourage attendance at family planning clinics. The impact of the programs was evaluated by (1) asking clinic users how they learned about the family planning services; (2) measuring the average rate of utilization during similar periods before and during the campaign; and (3) projecting attendance trends without accounting for the effects of the campaign and, then, ascribing the attendance difference to the campaign. The campaign costs of attracting each new user were between $9.54 and $17.72 in the 1971 campaign, $3.33 and $9.70 in the 1972 campaign, and $7.85 and $24.05 in the 1974 campaign. No evidence emerged to indicate that any one of the three evaluation methods was superior to the others, but the first method yielded results that were consistently intermediate between those obtained with the other methods. This suggests that this first method may perhaps be the best method to use, at least until further methodological evidence is available. 7 references.

81-1528
Assessment of Prospective Genetic Counseling in the Ferrara Area.
Barrai, I. and Vullo, C.
American Journal of Medical Genetics 6(3):195-204, 1980.

A group of 613 heterozygotes for beta thalassemia (267 married, 346 unmarried, averaging 23.7 years old), most of whom were screened at elementary school age, were interviewed to assess their knowledge of the heterzygous state and its implications. The subjects were interviewed in their homes or at the Microcythemia Center at the Pediatric Division in Ferrara, Italy. It was found that 83 percent of the subjects recalled some information about their condition; only 60 percent had some knowledge about the meaning of being heterozygous; and only 26 percent said that they knew of some relationship between Cooley's anemia and the heterozygous state for beta thalassemia. In the married group, the proportion of those having married another carrier was in agreement with random mating expectations. Thus, there is ample room for improvement in the procedures of delivery of prospective counseling at the population level in the Ferrara area. 5 references.

81-1529
Annotated Bibliography of Health Education Research Completed in Britain from 1948-1978.
Bell, J. and Billington, D. R.
Edinburgh, Scotland, U.K., Scottish Health Education Unit, 1 v., 1979.

Annotated citations of health education research completed in Britain during 1948 to 1978 are provided to assist health educators. Cited materials include descriptive and experimental studies on accident prevention, alcohol use, prenatal education, cancer, child care, dental care, diabetes, drugs, family planning, general health, heart disease, hygiene, immunization, medicines and self-medication, nutrition, organization and training for health education, highway safety, sex education, smoking, and venereal disease. The annotations cover the aims, methods, and results of the research studies. 287 references.

81-1530
Exploration of the Effect of Educational Level on the Nurse's Attitude Toward Discharge Teaching.
Caldera, K., et al.
JNE. Journal of Nursing Education 19(8):24-32, October 1980.

A study involving 285 registered nurses working various shifts in five acute-care hospitals was designed to assess the nurses' educational level (diploma, associate degree, or baccalaureate) on their perceptions of discharge teaching. Data were obtained by means of a 31-item questionnaire composed of multiple-choice questions, developed on the basis of professional experiences and a review of the selected professional literature. The instrument was pretested with registered nurses and revised according to pretest results. Generally, the findings indicate no significant difference among nurses of different educational levels. Questionnaire data indicated that (1) the majority of nurses felt that most hospitalized patients required discharge teaching; (2) 50 percent estimated that discharge teaching comprised 5 to 10 percent of their role; (3) 17 percent felt that discharge teaching comprised over 25 percent of their role; (4) 71 percent claimed to spend less than 5 minutes per day in discharge teaching; and (5) 91 percent used resources other than personal knowledge including textbooks, nursing publications, specialists, and research findings. A difference was found in the importance baccalaureate nurses placed on discharge teaching and their perception of the importance that the hospital placed on it. Neither diploma nor associate degree nurses revealed such a discrepancy. There is an obvious need for nursing education and services to work together to (1) delineate responsibilities for discharge teaching, (2) teach methods of implementing discharge teaching, and (3) instill in the nurse a sense of responsibility and accountability for discharge teaching. Finally, more research is needed to clarify patient needs and the current level of adequacy of discharge teaching. 43 references.

81-1531
Children's Thinking about Food and Eating--A Piagetian-Based Study.
Contento, I.
Journal of Nutrition Education 13(1, Suppl. 1):S86-S90, 1981.

A study involving 34 children, 5 to 11 years old, was designed to assess the subjects' thinking processes concerning food and eating from a Piagetian perspective; i.e., that knowledge is not received passively by a child but is constructed actively through thinking or reasoning experience. The children, who lived in an urban area and represented a variety of backgrounds, were interviewed in a semiclinical setting. The subjects were classified into preoperational and concrete operational stages on the basis of two standard Piagetian tasks: a conservation of substance task involving clay balls and a classification task in which the child is presented with pictures of birds, animals, and nonanimals and is asked to place them in specif-

ic groups. Preoperational children were not able to classify the pictures; concrete operational children understood classification. Interviewers asked open-ended questions, proceeding from the general to specific, to uncover the children's underlying cognitive structures and to distinguish their various levels of understanding. The taped interviews were classified by content and by Piagetian states. Results of the analysis indicated that (1) unlike concrete operational children, preoperational children considered all edible items as food and did not distinguish between food and snacks; (2) all preoperational and 71 percent of the concrete operational subjects believed vitamins were pills that made people strong or healthy; (3) only concrete operational children knew that food underwent transformation once it entered the body; and (4) as compared to concrete operational children, preoperational children had a wholly egocentric view of food. These findings indicate the need to replace conceptual instruction with concrete discussions concerning more specific matters, such as snacking versus eating nutritious food. 11 references.

81-1532
How Much Do Patients Know? A Multiple Choice Question Paper for Patients in the Waiting Room.
Coope, J. and Metcalfe, D. H. H.
Journal of the Royal College of General Practitioners (Edinburgh) 29(205):482-487, August 1979.

A questionnaire to assess knowledge of preventive medicine, medical treatment, and appropriate use of health services was administered to patients attending 10 different medical practices. Wide conclusions cannot be drawn as to the state of the public knowledge of health, since the respondents were patients rather than representative of the general population, the questionnaire was biased toward younger patients, and no record was kept of those patients who did not complete the questionnaire. However, the questionnaire, which revealed a need for health education, did emerge as a feasible method for estimating health knowledge in a patient population. The results of the 664 questionnaires indicated a social class knowledge gradient, a higher level of knowledge by women, and a low level of knowledge by the respondents in general. Suggestions are given for using the questionnaire method and for further studies with improved methods. A sample questionnaire showing the number of responses for each choice is appended. 11 references.

81-1533
The Belgian Multifactor Preventive Trial in CVD: Design and Methodology.
De Backer, G.; Kornitzer, M.; Thilly, C.; and Depoorter, A. M.
Hart Bulletin 8(12):143-146, December 1977.

The Belgian multifactor preventive trial in cardiovascular disease is a controlled epidemiological study of the influence of a preventive program on cardiovascular risk factor levels. In contrast with longitudinal, multifactor trials in Norway and the United States, the allocation of the sample population to control and experimental groups was not made on an individual basis; rather, whole occupational units were randomly allotted. Factories that agree to participate are arranged in matched pairs according to size and to nature of the occupational setting. One member of each pair acts as a control group while the other acts as an experimental group. All 40- to 59-year-old male workers are regarded as participants so that the effect of the preventive intervention on the community as a whole can be assessed. A central team of trained technicians performs standard screening examinations, which include blood pressure tests, health hazard appraisals, physical measurements, electrocardiograms, interviews to assess lifestyles, and serum cholesterol measurements. The intervention for the experimental group includes counseling interviews with high-risk individuals, combined with letters to their families and physicians. In addition, antismoking conferences, dietary counseling, and pertinent booklets and posters are provided to all experimental subjects. All high-risk subjects are examined at 6-month intervals, and random samples of all participants are examined periodically. 16 references.

81-1534
A Study of the Effect of a Health Education Programme in Promoting Seat-Belt Wearing.
Dillow, I.; Swann, C.; and Cliff, K. S.
Health Education Journal (London) 40(1):14-18, 1981.

A 6-month study involving two local authority districts within the Wessex Regional Health Authority, England, was designed to determine whether an integrated program of education could increase seatbelt use among front seat occupants. The Winchester District functioned as the target audience for the program, while the Salisbury District, which closely matches the Winchester District demographically, functioned as a control. A 2-week educational program in Winchester was followed by 2 months during which seatbelt wearing rates were measured, a week of reinforcement programming, and another 2 months of measurement. The educational programs involved distribution of bookmarks, poster displays, press releases, radio spots, a 20-minute presentation on a phone-in radio program, and television spots. Evaluation of the project was carried out by measurement of the seatbelt-wearing-rate taken in car parks in both districts;

and through a mailed questionnaire distributed to a random sample of the population drawn from the Winchester electoral poll. Tabulation of the data indicated that no significant change in seatbelt use had been induced by the program and that seatbelt use was negatively correlated with smoking. (It has been argued that smokers are a group of people who have different safety attitudes.) It appears that, at a local level, even coordinated public education programs do not influence seatbelt use.

81-1535
An Experimental Study: Patient Package Inserts and Their Effects on Hypertensive Patients.
Dwyer, F. R. and Hammel, R.
Urban Health 7(5):46-47, 56, 59-60, June 1978.

A study involving 18 male and 25 female hypertensive patients was designed to determine the optimal format and level of detail for patient package inserts (PPI's) needed to increase patient compliance in using antihypertensive medication. Seventy-five percent of the patients were from St. Louis Park Medical Center in a Minneapolis, Minnesota, suburb and the remainder came from the Arizona Health Science Center and the Veterans Administration Hospital in Tucson, Arizona. Various PPI's, each offering different amounts of information on drug side effects and effective behavioral reactions to side effects, were placed in coded bags and dispensed at the pharmacy using a double-blind procedure. Approximately 2 weeks after receipt of the drugs, willing patients were interviewed in their homes to determine comprehension of the PPI, recollection of receipt of the PPI, patient compliance to the drug regimen, and covariates of compliance. Data obtained from 41 subjects indicated that (1) only 3 could not remember getting the insert; (2) the inserts were given favorable ratings; (3) subjects averaged 61 percent correct answers on the knowledge test; (4) physicians and PPI's were rated as most helpful in gaining an understanding of the drug; (5) 60 percent of the subjects had retained the PPI's; and (6) the type of insert used had no effect on any pertinent variable. These and other findings indicated that extensive empirical research is not needed in the design of consumer information disclosure measures. 8 references.

81-1536
Some Major Obstacles to the Practice of Sound Nutrition in Nigeria.
Ekeh, H. E.
International Journal of Health Education (Geneva) 23(4):236-241, 1980.

A study conducted in Ibadan, the capital of the Oyo State of Western Nigeria, was designed to determine some of the environmental factors that may hinder implementation of nutrition education programming and the effect of health education on the children's nutritional status. Data were collected from mothers and from doctors and nurses at two child welfare clinics via interviews and questionnaires. The data indicate that (1) all mothers breast-feed their children; (2) by 6 months after birth, 94 percent of the mothers use the bottle even though only 53 percent know how to clean bottles properly; (3) more than 35 percent of all mothers introduce their children to local foods between 4 and 6 months old; (4) most mothers lack nutrition knowledge in several areas; (5) nearly all mothers keep excess food in cupboards; (6) nurses complain about the mothers' indiscriminate use of the bottle; (7) home visits improve feeding practices according to area nurses; (8) some nurses feel that superstitions affected some mothers; (9) both doctors and nurses indicate the need for more government aid; and (10) malnutrition does not seem to be a problem, although diarrheal diseases, respiratory infections, measles, and skin rashes are common. Problems associated with bottle feeding may be alleviated by better preparation of health personnel for their educational role; inclusion of family members in educational programs; and establishment of a health policy that supports preventive medicine, nutrition, and health education. 5 references.

81-1537
The Nurse as Health Educator: The Prevention and Early Detection of Cancer.
Elkind, A. K.
Journal of Advanced Nursing 5(4):417-426, July 1980.

Since nurses' attitudes significantly affect their role as health educators, 785 female hospital nurses in northwest England were surveyed to give their opinion of three prevention or early detection measures for cancer control--the cervical smear test, breast self-examination (BSE), and not smoking. Eighty-four percent responded positively for cervical smear test; 68 percent for BSE; and only 59 percent valued nonsmoking, though the later is regarded as the measure with the greatest potential for cancer control. Nurses' assessment of preventive measures is not based on the intrinsic clinical value of measures, but on the nurses' personal health behavior, particularly in regard to smoking. Ways for overcoming barriers to action must be explored before nurses will be prepared to fulfill their key roles in preventive health care education. 12 references.

81-1538
Drug Abuse is Alive and Well.
Frank, P. R.
Educational Forum 42(2):459-467, May 1978.

The positive view of psychoactive drugs taken by Western society must be demythologized if the nation's epidemic drug problems are to be curbed. Drug companies, pharmacists, and physicians have all contributed to the belief that medical intervention can revitalize the lives of nearly everyone. The public must realize that, although psychoactive drugs can reduce whatever inhibitions and anxiety or guilt a person might have about certain activities, particulary about sexual activities, they cannot of themselves generate such activities. Similarly, both the public and the professional community must come to realize that, although drugs can relieve symptoms of psychological and social disorders, drugs cannot eliminate the causes. Simple informational approaches and fear tactics have failed to combat pervasive drug abuse. New programming must aim at the two character dysfunctions most often associated with drug abuse, namely, the individual's inability to make rational decisions and low self-esteem. Authoritarian parents and teachers tend to lower children's self-esteem and inculcate few positive decision-making skills. Guidance of children in developing their own value systems, rather than imposition of preconceived value systems, should be the goal of parenthood and teacher education programs.

81-1539
Effectiveness of Two Procedures for Reducing Dental Fear: Group-Administered Desensitization and Group Education and Discussion.
Gatchel, R. J.
Journal of the American Dental Association 101(4):634-637, October 1980.

A study involving 19 adults who reported strong fear of dental treatment was designed to assess the effectiveness of two approaches to lower anxiety. Each of the two treatment groups met for six sessions over a 3-week period. In addition to a control group, the study design included a group that was trained in self-control desensitization and coping skills designed to reduce anxiety and a group that was involved in discussions about past and present experiences of anxiety associated with dental work. The self-control group was presented with the social learning rationale for the origin of anxiety. The group received training in relaxation and imagery that led to development of skills in desensitization. Two group leaders were assigned to each series. The success of the treatment interventions was assessed using a pre- and posttest design that employed the Corah Dental Anxiety Scale, detailed observations of patient anxiety during dental work, an instrument that allowed participants to rate the program, a review of dental appointment records, and responses to a researcher who posed as a potential program candidate. One-way analysis of variance of resulting data indicted that (1) both intervention groups lowered anxiety levels and improved appointment-keeping behavior significantly, (2) the self-control group was more successful than the discussion group in reducing anxiety, and (3) either approach can be implemented by dentists after a short training period. 9 references.

81-1540
Counseling for Drug-Tobacco-Alcohol Abuse: An Information Analysis Paper Based on a Computer Search of the ERIC Data Base November 1966 through December 1979.
Greenwell, G. S.
Ann Arbor, Mich., ERIC Counseling and Personnel Services Clearinghouse, 66 p., 1980.

A computer search of the ERIC data base for entries on drug, tobacco, and alcohol abuse counseling from November 1966 through December 1979 provides an overview of issues and trends in school and community prevention and treatment intervention strategies. The ERIC data base has several resource guides for drug abuse prevention programmers. Primary prevention, involving self-esteem reinforcement, is the exclusive intervention for drug abuse prevention at the elementary school level, while prevention programs at the junior and senior high school levels focus more specifically on drugs of abuse. The ERIC data base offers several complete program outlines for prevention of both alcohol and drug abuse for junior and senior high school students; values clarification and decision-making skills are central to these programs. ERIC citations concerning university and college programs include outlines for developing different prevention strategies and materials for teaching courses about drugs. Community-based programs on drug abuse in the data base focus either on community agencies or on the family. Motivation, treatment, and maintenance are central to the smoking education programs included in ERIC. Finally, ERIC files contain an abundance of information about tertiary intervention strategies for alcohol abuse. A copy of the annotated citations produced by the ERIC search is appended.

81-1541
Factors Influencing the Outcome of Health Campaigns: A Case Study in Singapore.
Ho, S. C. and Nam, A. C. E.
International Journal of Health Education (Geneva)

23(4):247-252, 1980.

A survey of 82 residents of dwelling units randomly selected from a middle-income urban community in Singapore was undertaken to assess the proportion of people who were able to recall a national health information campaign on infectious diseases. All persons more than 15 years old were interviewed, and a response rate of 81 percent was obtained. A total of 52.2 percent of the respondents indicated that they were aware of the campaign. When asked about knowledge on materials highly publicized in the campaign, 48.2 and 46.1 percent of the respondents gave satisfactory answers to questions of malaria and leprosy, respectively. The rate of correct responses to a question on food-borne diseases was 82.2 percent. Correct responses were most likely to come from young adults who were economically active and who had at least a secondary education. The most favored source of health education was television, followed by the print media. The high percentage of correct responses may be attributed to the fact that the campaign was part of an ongoing series. The survey revealed that few persons rely on community health centers for health information. 12 references.

81-1542
Effect of a Helping Skills Transfer Program on Dietitians' Helping Behavior.
Laquatra, I. and Danish, S. J.
Journal of the American Dietetic Association 78(1):22-27 January 1981.

Thirty nutrition students at Pennsylvania State University participated in a study to test whether their coursework resulted in effective communication in a clinical setting. The experimental group had previously enrolled in a course in effective interpersonal communication skills; the control group included students who had no previous training in any type of helping skills. The experimental group received a brief communication skills review program and reinforcement through instructor modeling and feedback. The control group received a program which merely reviewed dietary concepts in three health problem areas, with no reinforcement for using them. Results showed that students in the experimental group achieved a greater helping relationship and demonstrated accurate understanding of the client's problem. The experimental group was able to perceive the relevance of the helping skills and to internalize the rationale for using them in a nutrition co unseling environment. Findings are presented in three tables. 21 references.

81-1543
TAP: An Interactive Test Analysis Program for Health Education.
Maisiak, R.; Kellerman, J.; Williams, G.; and Scott, L. K.
Educational and Psychological Measurement 39(3):657-658, 1979.

The Test Analysis Program (TAP) is a comprehensive, flexible computer system designed to score and analyze objective educational tests. The goals of the designers were to construct a program that would be user oriented, flexible, and clear in structure and output. Salient features of TAP include interactive capability, basic test statistics (mean scores, standard deviations, reliability coefficient, and others), a grading list, a posting list and frequency histogram of scores, item analysis capability (including individual item discrimination and difficulty indices), capability to analyze separate test sections, opportunity for multiple response selections in multiple-alternative items, and assignment of item and alternative weights capability. The weighting of item alternatives and the opportunity for multiple selections allow the use of simple clinical simulation problems useful in health education. The system accepts up to 890 items per test, and input is by standard mark-sense forms and terminal interaction. The program is written in COBOL and FORTRAN for a Harris 120-4 using a TOTAL data base. TAP user manuals are available from the Office of Educational Development of the School of Medicine of the University of Alabama at Birmingham. 1 reference.

81-1544
Training School Staff for Alcohol Education. A Manual of Evaluation Guidelines for "Here's Looking At You"--A Model Program in Alcohol Education.
Mauss, A. L. and Hopkins, R. H.
San Francisco, Urban and Rural Systems Associates, 1 v. May 1979.

Guidelines are provided for teachers to evaluate the "Here's Looking At You" model alcohol education program. The program was developed in King County, Washington, for the Educational Service District No. 121 (ESD 121) Alcohol Education Curriculum Project. The manual outlines the development, rationale, and methodology of the ESD 121 evolution effort, focusing on key research questions, data sources, research instruments, and data analysis methods. Specific topics include student measurement instruments, teacher measurement instruments, adaptation or modification of instruments for local purposes, use of pre- and postprogram versus experimental-control data collection, data analysis, and evaluation reports. Data analysis techniques allow assessment of the

program's impact on students' knowledge, self-concepts, decision-making skills, attitudes, and alcohol use and experience. Appendices include copies of teacher and student instruments and consent letters for parents, scoring keys, a discussion of the validity and reliability of student instruments, a sample contract for use in securing a school district's cooperation, a summary schedule of the use of instruments, and a summary of data needs, sources, and modes of analysis.

81-1545
Adolescence and Alcohol.
Mayer, J. E. and Filstead, W. J.
Cambridge, Mass., Ballinger, 288 p., 1980.

An overview of state-of-the-art research on teenage drinking suggests future policy directions to improve and supplement the current treatment and prevention programs. Focusing on research involving 13- to 17-year-olds, the overview addresses the nature of adolescent drinking; the definition of adolescent use and misuse of alcohol; the extent and pattern of adolescent alcohol use; the influence of psychological, social, and cultural processes on adolescent alcohol use; and future research and policies that may affect alcohol use by adolescents. Specific topics addressed include a survey of 56,745 students to assess the extent and prevalence of illicit drug use; the epidemiology of drug use among New York State high school students; sex differences in adolescent alcohol and drug use; a theoretical model of adolescent alcohol use; dependency conflict and sex-role identity among drinking delinquents; the influence of peers and parents and sex differences in drinking by high school students; opportunity perceptions, alienation, and drinking behavior among Italian and American youth; a review of goals, approaches, and effectiveness of drug education and an example for evaluation; a critical review of alcohol education for adolescents; social norms and drinking behavior; and a conceptual framework for alcohol education in the elementary school. A selected bibliography is appended. Numerous references.

81-1546
Consumer Reactions to Differing Amounts of Written Drug Information.
Morris, L. A. and Kanouse, D. E.
Drug Intelligence and Clinical Pharmacy 14(7-8):531-536, July-August 1980.

An study involving 325 students from the University of Maryland attempted to determine the optimum amount of information that should be contained in a patient package insert (PPI). Four PPI's were prepared for the drug erythromycin. Each PPI offered side effects and general information, warnings, and behavioral instructions. However, the four PPI's differed in length and degree of elaboration. Prior to testing with the students, the PPI's were intensively examined by consumers recruited from the general population, who judged the medium-length PPI's as most desirable. After reading one version of the PPI, each student was administered a four section questionnaire to assess knowledge, evaluate the PPI on a set of semantic differential items, elicit beliefs concerning the rationale behind the PPI, and allow judgment of the PPI's readability. There was no difference in the total amount of knowledge communicated by the different PPI's, but results for individual test items indicated (1) more explicit information may be better recalled; (2) longer PPI's may aid in information integration; and (3) shorter PPI's may aid in pure recall of facts. PPI's containing elaborate explanations of side effects were rated as more accurate. Subjects tended to rate PPI's that provided behavioral instructions dealing with drug effects as designed to promote better care. 11 references.

81-1547
Effects of Nurses' Knowledge of Teaching-Learning Principles on Knowledge of Coronary Care Unit Patients.
Murdaugh, C. L.
Heart and Lung 9(6):1073-1078, November-December 1980.

A study involving 40 patients and 18 nurses in a coronary care unit of a community hospital on the west coast of the United States was designed to determine the effects of nurses' knowledge of teaching and learning principles on the knowledge of the patients. The patient population included myocardial infarction and congestive heart failure patients, up to 75 years old. A six-session, 12-hour course on teaching and learning principles, based on Knowles' adult learning model, was provided for the nurses. After 20 control patients had completed pre- and postprogram test instruments, the nurses took the course, which also involved pre- and postprogram testing. One week after completion of the course, the 20 experimental patients were processed along the same lines as the control patients. Results of the pre- and postprogram nursing evaluation instruments indicated that the nurses possessed sufficient knowledge, yet they lacked knowledge of educational principles. After the course, the nurses improved their knowledge of educational principles. A Z-transformation performed on patients' test data indicated that experimental patients, taught by the nurses after the latter had taken the course, were significantly more knowledge-

able about their conditions and treatments. A followup questionnaire, administered to the nurses 6 months after the study ended, indicated that inservice education courses in patient education are accepted and valued. 9 references.

81-1548
Assessing Nutrition Knowledge From an Information Processing Perspective.
Olson, J. C. and Sims, L. S.
Journal of Nutrition Education 12(3):157-161, July-September 1980.

Use of an information processing approach that provides a conceptual foundation for explaining the effects of nutrition knowledge on human food behavior focuses attention on the psychological processes involved in acquiring nutrition information, storing it in the memory, retrieving it at a later time, and using it in making decisions. The information processing model envisions acquisition of information through exposure, attention, comprehension, and rehearsal; formation of knowledge in the form of beliefs, attitudes, and behavioral intentions; integration of information through decision making; and selection of food types. Measures of the content and organization of consumers' nutritional knowledge structures that should be tested for validity include free elicitation tasks (subjects respond to cues presented by the researcher), repertory grids (subjects are asked to sort food by nutrition), traditional nutrition knowledge tests, and measurements of subjects' response times to specific stimulus tasks. Future research should examine how different types of knowledge structures are related to the use of new nutrition information for making correct food choices. 28 references.

81-1549
Belief Assessment as a Component of Curriculum Planning: Cigarette Smoking as an Example.
Roberts, S.
Journal of School Health 50(10):555-558, December 1980.

A study involving 142 women, 18 to 19 years old, enrolled in a large midwestern university was designed to assess salient beliefs and evaluations related to cigarette smoking among women. A subsample of 20 students was administered an open-ended questionnaire to assess perceptions about cigarette smoking; all students were administered a closed-format questionnaire based on those consequences most often elicited by the initial questionnaire. Results of a Hotelling T test of the mean score vectors of the answers from smokers and nonsmokers on the second instrument indicated that smokers believed only slightly that smoking would lead to bad breath, poor health, risk of cancer, breathing problems, dependency on cigarettes, and relatively large economic expenditures, while nonsmokers were much more likely to believe that these consequences resulted from smoking. Thus, planning further anti-smoking programs should incorporate the economic, social, and health costs of smoking, while suggesting alternative methods of tension relief and relaxation. Optimal evaluation of such programs would involve administration of closed-format questionnaires before and after intervention to assess belief and evaluation shifts. 5 references.

81-1550
Further Thoughts on Research Perspectives in Nutrition Education.
Sims, L. S.
Journal of Nutrition Education 13(1, Suppl. 1):S70-S75, 1981.

Research perspectives open to the pragmatic and eclectic nutrition education researcher include simple information dissemination, the Health Belief Model, ecological systems, information processing, behavior modification, and social-learning perspectives. The information dissemination model involves capturing the individual's attention, providing information, and allowing the individual to apply this information in effecting behavioral changes. Unfortunately, it appears that numerous psychosocial and environmental factors interfere with this process. Numerous statistical reports, including the dietary goals and guidelines published by the Senate Select Committee on Nutrition and Human Needs, have attested to the relationship between good nutrition and good health. Although the Health Belief Model (the interaction of a person's complex belief systems with social, economic, and environmental factors) is useful for descriptive purposes, the ecological systems approach (all factors affecting nutrition are interrelated and therefore form a system) is better suited for planned change efforts. Use of information-processing models (how a person processes information in light of current knowledge and how decision making is affected) to study consumer understanding of nutrition information allows assessment of the effectiveness of various interventions. Behavior modification strategies have been applied in practice to the greatest extent of any approach. Future research efforts should direct attention toward needs assessment, intervention strategies based on process criteria, and evaluation issues. 43 references.

81-1551
The Q Sort Technique Applied to Nutrition Attitudes Investigation.
Sutnick, M. R.
Journal of Nutrition Education 13(1, Suppl. 1):S102-S105, 1981.

The Q sort technique, a method developed and employed primarily by psychologists, can be adapted by nutrition educators to investigate preferences, choices, and attitudes toward food. When using the Q sort technique subjects rank a set of statements according to specific instructions. A food choice game, which incorporates this technique with sets of 25 cards with names of foods and beverages, has been tested with 266 junior high school students associated with the Nutrition Education Development Project (NEDP). The students were asked to sort the cards by preference and nutritive value. Comparison of sorting priorities of 266 experimental students, whose teachers had received inservice training under the NEDP, with the sorting priorities of 246 control students indicated that scores on written nutrition knowledge tests positively correlated with nutritive rank scores and that none of the correlations between preference and nutritive value rankings reached statistical significance. The Q sort technique can be used to investigate extremely fine distinctions in food preferences, understanding of dietary restrictions, self-esteem, and gaps in student knowledge. 10 references.

81-1552
Reflections on the Medical Model and the Objectives of Health Education.
Van Parijs, L.
International Journal of Health Education (Geneva) 23(4):205-215, 1980.

Recent trends in the health education approaches of Belgium, the Netherlands, France, and the United Kingdom indicate the need for more definite boundaries between health education and medicine. Since the rise of the social sciences, health education has separated itself from medical practitioners and has become firmly rooted in the behavioral sciences. The tendency of health education to focus on problem identification rather than on problem solution is due to the influence of the behavioral sciences. Health education specialists have remained aloof from specialists in communications and other educational fields. Though health education approaches in Eastern and Western Europe differ, the medical sector dominates neither. In fact, the multidisciplinary nature of the field is forcing countries such as the Netherlands and Belgium to search for alternatives to locating health education services in health services administration. The field's tendency to focus on singular medical problems, encourage health service utilization, and neglect social means to alter health behavior do not result from the dominance of the medical profession nor to avoidable strategies of professional practitioners. It appears that health education is based conceptually on a behavioral viewpoint and organizationally on a medical viewpoint, resulting in the neglect of communications, educational, and developmental fields by health education specialists. An approach to integrate the various disciplines would remedy this situation. 25 references.

81-1553
Do Children Influence Their Parents' Smoking? An Investigation of Parental Smoking Behaviour and Attitudes to Health Education.
Wilcox, B.; Gillies, P.; Wilcox, S.; and Reid, D.
Health Education Journal (London) 40(1):5-10, 1981.

A controlled study was conducted among parents of children in 14 primary schools in Sheffield, England, to investigate a possible "spread of effect" from a school antismoking project. The parents of children in eight Sheffield primary schools that offered the antismoking program formed the experimental group, and the parents of the children in the remaining six schools constituted the control group. Questionnaires, which employed closed-response items, were distributed to the schools and then to the parents via their children. Of the 499 households in the experimental group and the 558 households in the control group who received questionnaires, 366 and 368, respectively, returned the questionnaires. A followup study, conducted 3 months after the original study, involved interviews with a 10-percent random sample of smoking parents from both groups. Tabulation of the questionnaire data indicated that the antismoking program had not spread antismoking attitudes to parents, although this conclusion may be due to the small subject population or to the use of a laboratory-type design, in which only one variable was manipulated. Also, parental responses indicated an openness to discussing health matters with their children. 13 references.

81-1554
Life-Style and Future Health: Evidence from the Alameda County Study.
Wiley, J. A. and Camacho, T. C.
Preventive Medicine 9(1):1-21, January 1980.

In 1965, the Human Population Laboratory of the California State Department of Health Services conducted a

sample survey of noninstitutionalized adult residents of Alameda County, using mail-back questionnaires. Information about health status and lifestyle was obtained from 6,928 adults who were selected by area probability sampling. Of the 5,108 white respondents who were less than 70 years old in 1965, 3,892 were located and reinterviewed in a 1974 followup survey. Comparing data from the two surveys--regarding health status and health practices--indicated that cigarette smoking, alcohol consumption, physical exercise, hours of sleep per night, and weight in relation to height were significantly associated with overall health outcomes during the 9-year interval between the two studies. An index of health practices combining these five elements is associated with future health status within subgroups defined by socioeconomic level. These findings do not appear to be due to selective panel attrition or measurement error in the health indicator. The results provide support for the hypothesis that certain routine, discretionary behaviors play an important role in establishing an individual's level of disease resistance.

RISK REDUCTION

81-1555
Health Education-Risk Reduction Grant Program, FY 1980.
Bureau of Health Education (DHHS, CDC), Atlanta, Ga. Atlanta, Ga., the Bureau, 287 p., (1980).

Projects funded under the $15.9 million Health Education-Risk Reduction (HERR) grant program, administered by the Bureau of Health Education, are described. These State and territorial projects are capacity-building grants to establish a focus within each program to update and maintain an inventory of existing health education-risk reduction programs and services, establish and foster working relationships among agencies, determine risk factor prevalence data, survey and establish systems for acquiring chronic disease morbidity and mortality data, and help communities develop organized approaches to risk reduction. Fifty-four State and territorial projects, 21 local intervention projects initiated in 1979, and 144 newly initiated local intervention projects were funded. Each program description includes the name of the applicant, a description of the target group, program objectives, methodology, and evaluation plans. Also included are (1) a map showing the geographic areas covered by the programs; (2) a chart showing the target group, target risks, setting, methodology, and funding level for each program; and (3) pages from the Federal Register detailing rules and regulations that govern the HERR program.

81-1556
Risk Factor Changes in the Belgian Heart Disease Prevention Project.
De Backer, G., et al.
Acta Cardiologica. Supplementum (Bruxelles) 23:125-132, 1979.

A study involving 16,222 workers, 40 to 59 years old, from 30 factories was designed to assess the efficacy of the Belgian Heart Disease Prevention Project in lowering cardiac risk factors affecting workers. The factories were arranged in pairs, with one member of each pair acting as a control group and the other acting as an experimental group. All participants of the experimental group and 10 percent of control group participants underwent screening for cardiovascular risk factors; the remaining 90 percent of the control group underwent resting electrocardiograms. All participants who underwent full screening were screened further to provide risk profiles. The subjects in the top 20 percent of the risk score distribution were designated as high-risk subjects. A 6-year followup program is underway. The experimental intervention program involves distribution of booklets, a mass counseling program, contacts with participants' physicians, and individual counseling for high-risk subjects. Data from the first 2 years of the followup period and preliminary data from the subsequent 2 years indicates that (1) systolic blood pressures among the experimental group have decreased significantly in comparison with the rates of the control group, (2) average serum cholesterol levels increased for the control group, but decreased for the experimental group, and (3) 12 percent of the high-risk controls as compared to 19 percent of the high-risk experimental subjects had ceased smoking. Thus, it appears that the program has been successful.

81-1557
Invited Response to Congressman Richmond: Another View of the Politics of Cholesterol.
Harper, A. E.
Journal of Nutrition Education 12(4):187-188, October-December 1980.

Contrary to the charges of Congressman Fred Richmond (14th District, New York), the Food and Nutrition Board's (FNB) publication concerning dietary recommendations for Americans does not disregard epidemiologic evidence about relationships between dietary cholesterol intake

and the incidence of heart disease. Rather, in agreement with the American Society for Clinical Nutrition, the FNB recognized that when associated variables are accounted for, there is little correlation between dietary cholesterol and either serum cholesterol concentrations or mortality rates from coronary heart disease. Nevertheless, the Congressman's attack has been of great value in creating public awareness of the depth of the controversy about postulated diet-disease relationships and about the political nature of health advice. 4 references.

81-1558
The Medicine Called Nutrition.
Mason, D. T. and Guthrie, H., eds.
Englewood Cliffs, N. J., Best Foods, 67 p., 1979.
Available from: Best Foods Nutrition Information Service, Box 307, Dept. MCN-HP, Coventry, CT 06238.

Comprehensive information is provided about contemporary nutrition and the means by which nutrition can prevent and treat disease. The program includes an overview of the nutritional status of the country; the roles of proteins, fats, and carbohydrates in diet; the role of nutrition in prevention and treatment of hypertension, atherosclerosis, obesity, cancer, and diabetes; and current views on lipid, lipoprotein, and fat metabolism. Clarity is enhanced through ample use of graphs, diagrams, and charts.

SCHOOL HEALTH EDUCATION

81-1559
Missouri Conference on Comprehensive School Health Instruction for Decision Makers, March 23-24, 1979, Jefferson City, Missouri; Proceedings and Recommendations.
Jefferson City Mo., Missouri Department of Elementary and Secondary Education, 59 p., 1979.

A statewide conference on comprehensive school health instruction was held for Missouri health education policymakers in Jefferson City on March 23 and 24, 1979. Occurring at the end of a 3-year development of guidelines for a comprehensive school health education program for grades K-12, the conference was designed to identify priority school health instruction needs and conditions necessary for local schools to implement a comprehensive curriculum. Recommendations were made for a State plan to provide a cooperative health assistance program to schools using local health agencies and organizations to implement the curriculum. Topics addressed included disease control and personal health, safety and first aid, community and environmental health, consumer health, mental health and substance abuse, family life and sex education, and nutrition education. Recommendations were made in the areas of classification and accreditation for programs, preparation for teachers attending State colleges and universities, program evaluation, requisite health services, the role of the school nurse, instructional requirements, personnel requirements, inservice training for teachers and other school personnel, and model school lunch programs. The conference program agenda and a list of the conferees are appended.

81-1560
Aging: A Need for Sensitivity.
Briggs, K. A.
Health Education 8(5):37-38, September-October 1977.

School health education is an appropriate forum for a discussion of the problems of the elderly. Many students lack direct contact with elderly persons in their communities, and this may result in insensitivity to the needs of senior citizens. Students are often ignorant about the process of aging and ill-prepared for their own old age. Recommended classroom activities can include sensory deprivation simulation, role playing, popular songs about the old, discussions of popular opinions and misconceptions about aging, films, and talks given by senior citizens. Such school-focused programs can reintroduce the older generation to those out of touch with them, as well as provide a forum for serious questioning of America's youth-oriented culture.

81-1561
Health Education and the School Curriculum: The Case for Infant Feeding.
Finch, J.; Clayton, S.; and Clements, J.
Health Education Journal (London) 40(1):19-23, 1981.

Numerous issues emerge when considering the possibility of including infant feeding within the general context of parent education. The rationale underlying the inclusion of this topic in parenthood education rests upon the general arguments for the inclusion of parenthood education and upon the particular issues about individual choice of feeding method. National surveys of high school students' needs and knowledge indicate an openness to such topics by both sexes and a wide variation in the depth of student knowledge in the area of infant nutrition. The resocialization or behavior modification approach to health educa-

tion cannot be applied to infant feeding since it is not a politically or morally neutral practice. Since the simple information-giving approach does not guarantee outcomes, the self-development model, with its emphasis on development of decision-making skills, seems to be the most appropriate approach. Such an approach takes account of the social and cultural contexts in which health decisions will eventually be made and implemented. Teachers, rather than medical professionals, would be the logical instructors in the self-development approach since they are familiar with the educational needs of children and since they are the ones who present other subjects to the students. 12 references.

81-1562
Building a Better You. A Guide for Health Education in Georgia Schools--Kindergarten Through Grade Six.
Georgia State Dept. of Education, Atlanta.
Atlanta, Ga., the Department, 2 vol. 255 p., 1980.
Available from: ERIC; Order No. ED-187 701.

Comprehensive teacher guidelines are provided for implementing a health education program for elementary school students in Georgia. Topics addressed include policies and procedures pertinent to school health programming, course content for students in kindergarten through third grade and fourth through sixth grade, and means of integrating and correlating a learning block in a sequential order. Health education areas include emergency care, family living, personal growth and human sexuality, immunizations, nutrition education and school food services, physical education and athletics, and physical examinations. Each school should have a school health committee and should develop guidelines in school health for use by administrators and teachers. A community-wide health council, which can be a committee of the PTA, should be developed to allow input by parents, teachers, school administrators, the community health department, medical and dental professionals in the community, and volunteer health and social agencies. Numerous pertinent forms, booklets, curriculum guides, films, resource materials, and similar materials are listed in the appendices.

81-1563
Prevention of Cigarette Smoking in Seventh Grade Students.
Hurd, P. D.; Johnson, C. A.; Pechacek, T.; Bast, L. P.; Jacobs, D. R.; and Luepker, R. V.
Journal of Behavioral Medicine 3(1):15-28, March 1980.

An 8-month school-based smoking prevention program was tested on all 1,636 seventh grade students enrolled in Minnesota Independent School District 281. The school district is in a predominantly white suburb of Minneapolis-St. Paul. The four schools involved were each assigned to different treatment conditions, which included a social pressures curriculum consisting of videotape presentations and discussion groups and role playing led by college students; a personalization curriculum consisting of student-selected peers and a videotape presentation; a commitment curriculum intervention whereby students completed the sentence "I'm not going to smoke because..."; and a closely monitored (saliva test) control group and a control group that was monitored by a saliva test only at the end of the treatment period. Evaluation instruments included saliva monitoring and administration of a questionnaire about smoking habits. Curriculum elements that deterred smoking onset were (1) emphasis on immediate and primarily social consequences of smoking, and (2) personalization of the course materials and mode of presentation to include relevant peer role models and active individual role playing. 33 references.

81-1564
The School Health Curriculum Project: A Study of Frequency of Participation to Impact.
Iammarino, N. K. and Heit, P.
International Journal of Health Education (Geneva) 23(4):242-246, 1980.

A study involving 395 eighth-graders enrolled in the National Clearinghouse for Smoking and Health School Health Curriculum Project was designed to determine the smoking attitudes and behaviors of the students. A quasi-experimental design, known as the static group comparison method, was selected because use of pretest measures was not possible with the population. The Department of Public Health's Teenage Self-Test, supplemented with behavioral and demographic items, was used to measure attitudes and behavior regarding cigarette smoking. Data were analyzed with the chi-square test of homogeneity and the analysis of variance technique. Findings indicated that students who participated in all three curriculum units (lung, heart, and brain) did not achieve significantly higher mean scores on eight smoking-attitude scales and did not differ significantly in smoking behavior from those students who participated in only one or two of the units. Thus, changes in attitudes and behavior were not proportionate to the intensity and frequency of the intervention. 9 references.

81-1565
The State of School Heart Health Education: A Review of the Literature.
Iammarino, N. K.; Weinberg, A. D.; and Holcomb, J. D.
Health Education Quarterly 7(4):298-320, Winter 1980.

A review of the literature on modifiable risk factors associated with heart disease and on school heart health education indicates an interest among health educators in the development of prevention programs. The major topics addressed by the school heart health education literature in the last 10 years include incidence of cardiovascular risk factors in the school-age population, need for health education due to the status of adolescent heath and problems of motivation, and evaluations of current heart health education projects. General trends found in the literature indicate that (1) there is a need to be concerned with the cardiovascular health of young people; (2) the need for educational programs using proven methods of prevention is well documented; (3) studies have found that adolescents do not have sufficient knowledge to prevent cardiovascular disease; (4) well-designed programs can be effective in increasing health knowledge and promoting positive attitudes; (5) some programs have encouraged behavioral change; (6) most programs have proven too expensive to become integral components of typical curricula; and (7) research should be aimed at making effective heart health education feasible by the end of this decade. 102 references.

81-1566
Health Education to Improve Rubella Immunisation in Schools.
Jones, S. A.
British Medical Journal (London) 281(6241):649-650, September 6, 1980.

A study involving 944 female students, 11 to 12 years old, attending their first year at seven Inner London comprehensive schools, was designed to assess the efficacy of health education in promoting the uptake of rubella immunization. The schools were divided into control and experimental schools, and experimental schools were further divided into a group that received a short lecture on rubella supplemented by slides and a group that received the same intervention followed up a few days later by an informal discussion. All study subjects were administered a questionnaire designed to elicit demographic information and attitudes and intentions about the rubella vaccination. There was no significant difference between the control and experimental groups concerning questionnaire responses. Nevertheless, an uptake of 93 percent was achieved in the experimental group as compared to 75 percent in the control group. Thus, it appears that a low-cost education program can be successful in raising immunization rates for rubella, which usually range from 61 to 81 percent. 4 references.

81-1567
Lead Poisoning: A Need for Education.
Lipnickey, S. C.
Health Education 12(2):7-10, March-April 1981.

A review of the causes, symptoms, and treatment of lead poisoning provides background for the educational implications of lead poisoning prevention programs for schoolchildren. Sources of lead that contribute to poisoning include lead-based paint, automobile emissions, lead dust in chalk, lead-glazed ceramic tableware, newsprint, water from lead pipes, and decorative decals and glazes. Dietary components and deficiencies as well as pica (the compulsive ingestion of nonfood substances) affect the lead levels in children's bodies. Families in which parents work in lead-related industries and urban minority families are the most likely to have children with high lead levels. Funding to finance screening efforts for young children in high-risk areas is available through the Lead-Based Paint Poisoning Prevention Act of 1971. Teachers and other school personnel should be able to recognize the symptoms of lead poisoning, determine children's eating behavior, and refer children to local screening resources. The chronic nature of lead poisoning requires long-term environmental investigation and intervention, involving meetings between the parents and a health team consisting of the teacher, school nurse, health educator, and pediatrician. Finally, prevention of lead poisoning requires classroom programs, inservice training for teachers, and adult education programs. Numerous references.

81-1568
What the Doctor Can Do to Improve the Health Education of School Children (Editorial).
Plumb, R. L.
Texas Medicine 75(11):100, 1979.

The physician is uniquely qualified to lead the community in development of school health education programs. Physicians are competent to act on school health committees, evaluate existing programs, become active in local medical society activities pertaining to school health, run for positions on the local school board, and act as school physicians. The School Health Medical Advisory Committee of the Houston Independent School District is composed of physicians in various disciplines who represent the local medical society, pediatric society, and medical

schools. The committee meets regularly to advise school officials on health education matters. In addition, the district has implemented a program entitled "Children Take Command" to improve the health of individual school populations with the aid of a physician adviser assigned to each school.

81-1569
You and Your Health: Activity Booklet (Level Eight).
Pounds, E. T.
Glenview, Ill., Scott, Foresman, 32 p., 1977,

A health and safety activities booklet to be used with the "You and Your Health" program is provided. The activities, which can be used by individuals working alone or by school or other groups, are related to skills in human relations, dental care, personal health, skin problems, nutrition, safety, smoking, alcohol and drug use, consumerism, recognition of health quackery, use of medical resources, public health awareness, pollution control, and careers. Worksheets contain quizzes and opinion questions, answers, and information to be shared at home.

81-1570
This School Board Found a Way to Save Lives by Providing Students and Volunteers With Training in C.P.R.
Robinson, Z.
American School Board Journal 167(2):28-29, February 1980.

The school board of Southfield, Michigan, has offered the school system free cardiopulmonary resuscitation (CPR) instruction for students and adults. The idea developed from a suggestion made at the Michigan Association of School Boards orientation session in 1976 that one member from each school learn CPR techniques. In 1978, the Southfield Board authorized CPR training for all custodians in the school system. Inservice training for faculty members was provided at one middle school so that CPR could be offered as an optional portion of the science curriculum. A hospital-based program eventually evolved to teach 10,000 city residents CPR. The 4-hour course which was publicized on local television, was offered at a local high school, a parks and recreation department facility, and the hospital. The three sites shared the necessary equipment. Since the community goal of 10,000 certified CPR practitioners was reached and the survival rates of heart attack victims increased markedly, the board has considered inclusion of CPR training as a requirement in the secondary school curriculum.

81-1571
Coping with Death and Dying (including Teacher's Guide).
Russel, R. D. and Purdy, C. O.
Glenview, Ill., Scott, Foresman, 64 p., 1980.

Information on death and dying is presented for elementary school children including communication about death and dying, death by choice, death and dying in the news media, physiological processes of dying, causes of death, suicide, psychological stages of dying, adjustment to the death of a loved one, decision-making vis-a-vis death and dying, funerals and burials, the written will, the definition of death, the right to die, alternatives to death, and controversies surrounding issues related to death and dying. Provocative questions, informative activities, lists of suggested readings, and a teacher's guide are provided to supplement the textual material.

81-1572
Maryland's Student Committee on Drug Abuse (SCODAE).
Tommasello, T.
American Pharmacy 20(12):26, December 1980.

The Maryland Student Committee on Drug Abuse Education, a program sponsored by the Department of Pharmacology and Toxicology at the University of Maryland at Baltimore, trains pharmacy students to make presentations on drug abuse to high school students and other groups. Volunteer student speakers provide a five-part course on drug education for public schools that covers an overview of drugs and addiction, the physiological effects of drugs, alcohol and depressant drugs, amphetamines and stimulants, and marijuana and psychedelic drugs. The program also develops and revises specialized programs of drug education and information dissemination for a variety of professionals. Presently, program speakers address more than 6,500 persons annually; 21 percent of these are drug abuse or alcohol counselors and more than 20 percent of the hours are provided to professional audiences. The program also publishes a technical newsletter on psychoactive drugs and drug abuse treatment that has 6,000 subscribers and serves as a nonemergency drug abuse information center, providing data and general information to researchers, clinicians, and the public.

81-1573
Evaluation of School Health Programmes. Report on a Working Group, Bucharest, 2-5 August, 1977.
World Health Organization, Copenhagen (Denmark). Regional Office for Europe.
Copenhagen, Denmark, the Organization, 30 p., 1977.

Available from: NTIS; Order No. HRP-0030834.

School health was the topic of discussion at a working group organized in Bucharest, Romania, in 1977 by the World Health Organization's Regional Office for Europe. As envisioned by the working group, the purpose of school health programs is to promote the health and functional capacity of students by providing optimal physical and social environments and educational conditions; promoting healthful behavior through health education; and providing school health services for early detection of disease and impairment and for the comprehensive treatment of problems that can be dealt with only in close connection with the school environment. The evaluation of special school health problems is crucial. These problems include neurological dysfunction, visual disorders, dental health problems, and behavioral problems. The involvement of medical staff, sociopsychological staff, parents, and students in school health programs is also essential. The present situation in the area of school health in Europe requires that (1) each national group decide its own objectives and priorities; (2) multidisciplinary health teams be used to assess the needs of each community and implement programs; (3) local authorities and medical schools become involved in school and community health education; (4) handicapped children be integrated with normal children; (5) vision and dental health programs be implemented for preschoolers; and (6) models developed by the working group be used to integrate schools and child care services. A list of participants and an overview of statistical research is appended.

SELF-CARE

81-1574
Healthism and the Medicalization of Everyday Life.
Crawford, R.
International Journal of Health Services 10(3):365-388, 1980.

A critique of the new health consciousness and health movements--holistic health, self-care, and self-help--is offered. "Healthism" is defined as a preoccupation with personal health as the prime standard of well-being, which, it is argued, fosters continued depoliticization and therefore undermines social efforts toward health promotion and contributes further to medicalization of the culture. Medicalization is closely linked with the institution of medicine and the concepts of health and illness, thereby expanding professional power over wider spheres of life, deviant behavior in particular. The notion of deviancy is extended from the sick person to the potentially sick, from manifest illness to unhealthy at-risk behavior. Healthism reduces health issues to one dimension in which an expanding number of experiences are judged by health values. Health becomes less a means than an end in itself. The struggle for generalized well-being, redefined as health, becomes increasingly private. Healthism serves a social control function by mystifying and channelling discontent into forms which are basically nonthreatening to the existing order. While political activists in the occupational and environmental health movements tend to have a singular focus on factors external to the individual, healthists are preoccupied with the subjective, behavioral arena. The isolation imposed on the two realms--subjective and objective--misses the dialectical essence of social existence and serves the interests of domination. A genuine holistic health demands a holistic society. 73 references.

81-1575
Self-Care Nursing Plan: Helping Children to Help Themselves.
Eichelberger, K. M.; Kaufman, D. H.; Rundahl, M. E.; and Schwartz, N. E.
Pediatric Nursing 6(3):9-13, May-June 1980.

A self-care nursing plan for pediatrics has been developed within a framework of childhood development using Orem's self-care theory of nursing as a basis. Orem designates the nurse's function as removing obstacles to self-care by enhancing the patient's capabilities or altering the patient's self-care demands. Extension of the theory to include children as possible self-care agents and to encompass wellness as well as illness as a focus of care allows the child, the parent, and the nurse to work together to enhance the child's self-care abilities. 2 references.

81-1576
Discovery of the Self in Health Care (Editorial).
Friedman, F. B.
Journal of Practical Nursing 30(9):6, 38, September 1980.

The American public is discovering that individual responsibility is an integral component of the health care system. This awareness has stimulated alternatives or additions to traditional health care. The new consumerism in health care arises from a growing distrust of professional health care systems as well as from patient recognition that they can contribute toward their own level of well-being. Health workers with close patient contact can maximize

the benefits of consumer attitudes by encouraging self-care and by providing health education and supportive understanding. Nurses can organize support groups for patients and their families as an important step toward promoting individual health responsibility. This collective approach to self-care provides a forum for mutual support and technical information. Nurses and other health workers can fill a vital role in providing guidance and expertise in both individual and group self-care efforts.

81-1577
Some Suggestions for "Self-Help" Approaches with Street Drug Abusers.
Hawkins, J. D.
Journal of Psychedelic Drugs 12(2):131-137, April-June 1980.

Residential self-help programs, which have been successful in dealing with alcoholics, smokers, overweight persons, and other persons with behavior control problems, have potential for helping street drug abusers. Key characteristics of the self-help approach are the involvement of participants in solving problems of others as well as their own, the presence of a reference group of similar individuals who provide a support network, and the encouragement of individual members to adopt a new view of themselves through a conversion process. Characteristics typical of the street drug abuser include relinquishment of roles associated with "straight society," lack of close personal ties with persons in the abuser's social network, acceptance of the label "junkie," and development of a full range of manipulative behavior. The residential self-help approach allows the abuser to be converted, to assume a new identity and self-concept, and to develop behavior patterns consistent with that identity. Residential programs, however, must be followed by transitional non-residential programs in an alternative to traditional re-entry programs for street abusers. 23 references.

81-1578
A Self-Help Program for Childhood Asthma in a Residential Treatment Center.
Richards, W.; Church, J. A.; Roberts, M. J.; Newman, L. J.; and Garon, M. R.
Clinical Pediatrics 20(7):453-457, July 1981.

The Sunair Home for Asthmatic Children in Los Angeles, California has developed a self-help program for asthmatic children which can be adapted for home use. Parents of each child view a slide-tape presentation concerning asthma, discuss the disease and the therapeutic plan with a physician, and receive printed material developed by the American Lung Association. Each child is assigned to an educational category based on age and level of understanding. All patients over 6 years old are placed in the self-help program. The children's educational program consists of a slide-tape presentation, group discussions, and reading material. Periodic quizzes are conducted to evaluate program impact. The treatment team includes the patient, physicians, a primary-care nurse, a social worker, and, in some cases, a psychiatrist. The children are trained in self-administration of medications, and their abilities in this area are evaluated three times daily. The performance ratings and clinical conditions of 23 children participating in the program were evaluated over a 9-month period. Many of the children demonstrated clinical improvement after the program. Inclusion of the patient in the program, recognition of the severity of chronic asthma, and recognition of the psychosocial factors that affect treatment have made the program a success. 4 references.

SEX EDUCATION

81-1579
Films for Family Planning Programs.
Population Reports. Series J; Family Planning Programs No. 23:J493-522, January-February 1981.

Citations of films are provided for health educators and other health professionals for use in family planning programs. Film topics include population awareness; model family planning programs; family planning in integrated services; adolescent fertility; contraception; reproduction; medical information about contraceptives and sterilization; and training of program managers, planners, communicators, and educators. Each citation includes the film's title, producer, distributor, language, intended audience, setting, format, length, date of production, and price, as well as a short commentary describing the subject matter and highlights of the film.

81-1580
Family Life Education Comes to New Jersey.
NJEA Review 54(1):16-18, September 1980.

The New Jersey Board of Education approved revisions to the comprehensive, controversial, mandatory, family life education program required to be implemented in all school curricula by September 1983. Objections ranged from the unnecessary aspect of the statewide mandate, to participation of clergy in curricular planning, and unclear

procedures for excusing students. Further concerns focused on preference for local school board control, anxiety about public scrutiny, and funding for inservice training. The student opposition to the program was voiced on moral and religious grounds, with stated intentions to seek legal recourse. The regulations provide for curricula outlines to be sent to parents who may remove their children from life education class upon request. Curriculum planning committees include professionals from a broad range of disciplines; designated teachers of the courses include those with certificates in biology, comprehensive science, elementary education, health economics, psychology, school nursing, family life, and nursery education. A copy of the revised regulations is appended.

81-1581
Teenage Pregnancy: A Handbook for Teachers, Parents, Counselors, and Kids.
Baum, D. J.
New York, Beaufort Books, 157 p., 1980.

Guidelines to help teachers, parents, counselors, and adolescents deal with the problems associated with adolescent pregnancy are provided. Topics addressed include estimation of the extent of the problem of teenage pregnancy, the problems of the teenage mother, teenage fathers, sex education and birth control, the law and its impact, decision making involved in choosing adoption or abortion, community programming, and education for parenthood. Numerous references.

81-1582
Sex Education Belongs in School.
Brick, P.
Educational Leadership 38(4):390-391, 394, February 1981.

The 8-week sex education unit taught at Dwight Morrow High School in Englewood, New Jersey, is part of a behavioral science course and involves anthropological, sociological, psychological, and ethical perspectives. Student concerns covered in the curriculum include the accuracy of home pregnancy tests, sexual stimulation, effects of masturbation, venereal disease symptoms, effects of abortion, and "safe" periods to have intercourse. The unit begins with administration of a 70-item sex knowledge survey directed at common misconceptions about sex. Following a 2-day period during which students attempt to find the correct answers, the questions are discussed. Subsequently, anthropological and sociological works are studied to broaden students' definition of sexuality. Student research into body language, sexist behaviors, homosexuality, premarital sex, development of sexuality, birth control, and abortion makes them aware of the associated issues. A 45-item checklist of sexual concerns allows the adolescents to reveal insecurities about sexual relations. Role playing and values clarification exercises are used extensively, and the students develop a code of sexual behavior. A survey of students who participated in the unit during one year indicated that they felt better about their sexuality and decision-making abilities. 23 references.

81-1583
Sex Counseling of the Disabled in Medical Practice.
Comfort, A.
In: Sexual Consequences of Disability. Comfort, A., ed. Philadelphia, Pa., George F. Stickley Co., p. 5-9, 1978.

Little educational material or programming has been developed to help provide sexual counseling for patients with certain forms of physical disabilities such as spastic paralysis, rheumatoid arthritis, multiple sclerosis, and many other chronically disabling disorders. Effects of drugs--particularly antihypertensive drugs--and some forms of surgery on the sexual abilities or desires of patients necessitate careful sexual counseling by the physician. The pattern of patient management should include determination of the exact extent of the physical problem, expansion of sexual activities by education and permission, and establishment of goals for patients undergoing rehabilitation or for disabled patients developing sexual skills. Problems with sexual disabilities most commonly seen in office practice are associated with interference with habitual sexual behavior by a relatively minor disability or by side effects of medication, convalescence from coronary heart disease, and sequelae of common surgical procedures. 3 references.

81-1584
The Acquisition of Sexual Information by Young People.
Courtright, J. A. and Baran, S. J.
Journalism Quarterly 57:107-114, Spring 1980.

A secondary analysis of a study designed to examine the influence of sex in the media on the perceptions of 202 high school and 207 college students in Cleveland, Ohio, was conducted to assess the relative influences of peers, family, and television and film on the student's perceptions. Data from questionnaires designed to measure the perceptions of the students provided information on each student's sexual experiences, enjoyment and sex, demographic background, sexual experiences of friends, and perceptions of sexual prowess of characters appearing in

the media. Results of a multiple regression analysis and canonical correlation analysis indicated that (1) virginal high school students were less satisfied than their collegiate counterparts; (2) satisfaction with coitus was unrelated to age or educational attainment; (3) males were significantly more satisfied with coitus than females; (4) peer and media influences were significantly correlated and could not be separated into discrete sources of influence; (5) sexually active students were less likely to believe the portrayal of sexually active media characters; (6) peers and mass media were powerful agents in acquisition of sexual information; (7) sexual socialization as manifested by coital satisfaction was wholly media-based; and (8) family influence showed no impact in the face of media and peer influences. Numerous references.

81-1585
The Human Story: Facts on Birth, Growth, and Reproduction.
Hofstein, S.
Glenview, Ill., Scott, Foresman, 48 p., 1977.

Material on birth, growth, and reproduction is provided for 10- to 14-year-old adolescents. Topics discussed include sexual development and maturation, overt and latent changes during adolescence, development of female sex organs, female sex cells, the menstrual cycle, menstrual hygiene, development of male sex organs, male sex cells, sexuality as one aspect of maturity, conception, pregnancy, development of the fetus, birth, breast-feeding, the newborn baby, heredity, genes, and the relationship between heredity and environment. A list of suggested readings and a glossary of terms are appended.

81-1586
The Effects of School Sex Education Programs: A Review of the Literature.
Kirby, D.
Journal of School Health 50(10):559-563, December 1980.

A review of the literature on the evaluation of school sex education programs and the impact of such programs on the knowledge, behavior, and attitudes of students indicates that there is a vast array of approaches taken by various institutions. The most common method of analyzing the effects of sex education, namely, the experimental design, has been misused by many researchers in that (1) most studies evaluate single programs that have not been randomly selected, (2) evaluators are rarely able to assign students randomly to experimental and control groups, (3) very few studies measure long-term effects, (4) assessment instruments are often poorly designed, and (5) few studies provide good indicators for the magnitude of change brought about by various interventions. Concerning results, it appears that (1) sex education courses can increase students' knowledge; (2) some programs facilitate attitudinal change, particularly if that is the goal of the program; (3) programs appear to have little effect on sexual behaviors such as petting or intercourse; (4) courses that emphasize contraception may increase use of effective contraceptive methods; (5) programs that integrate instruction and the provision of contraceptives can be highly successful in reducing pregnancies; and (6) educators should carefully select program goals before designing the program. 48 references.

81-1587
Survey of Sex Education Coursework in Special Education Programs.
May, D. C.
Journal of Special Education 14(1):107-112, Spring 1980.

A survey of the chairpersons of 185 special education teacher-training programs was designed to determine the amount and type of coursework in sex education that their student teachers received. Of the 146 program chairpersons that responded to the mail survey, 61 percent indicated that their students received some preparation in sex education. Further analysis indicated that the majority of coursework involved either elective options or a few hours of coverage within existing courses. The need for training programs to assist teachers in integrating sex education into their coursework is highlighted by these findings. Effective programming could involve a separate sex education course offered by the special education department, a team-taught course involving other departments, or a major component in a teaching methods course. Departments that have few slots available for such programming should consider offering concentrated workshops, developing self-instructional modules, or offering a noncredit program resulting in the issuance of a certificate. 17 references.

81-1588
Understanding Your Sexuality (Including Teacher's Guide).
Purdy, C. O. and Kendziorski, S.
Glenview, Ill. Scott, Foresman, 112 p., 1980.

Textual material and accompanying guidelines for the teacher are provided for use in a sexuality education course for adolescents. Topics receiving attention include sex roles and responsibilities, the human reproductive sys-

tems, conception, pregnancy, childbirth, communication and dating, dating and sexual behavior, marriage and other lifestyles, varieties of sexual behavior, choices about parenthood, and sexually transmitted diseases. The teacher's guidelines contain suggestions pertinent to each topic.

81-1589
Use of a Sex Rap Group in an Adolescent Medical Clinic.
Scharff, D.; Silber, T.; Tripp, G.; McGee, E.; Bowie, S.; and Emerson, B.
Adolescence 15(60):751-762, Winter 1980.

The Adolescent Clinic at Children's Hospital National Medical Center in the District of Columbia has offered a sex rap group during the past 5 years as an integral part of the clinic's comprehensive birth control services. The group, which was created in cooperation with the sex education and counseling service of Preterm (a private sex education agency), is led by members of an interdisciplinary staff that includes a sex education counselor, nurse, pediatrician, and psychiatrist. Attendance by 13- through 19-year-olds, who have participated in the group, has fluctuated. Most participants are referred from the clinic for sex-related problems. "Veteran" members of the group act as peer educators, putting the group at ease and creating a sense of group identity. A wide variety of demonstration materials, films, pamphlets, slides, and books have been used at the informal 90-minute sessions, which include role plays, debates, and discussions. Experiences with the 300 adolescents, who have participated in various groups, indicate that each group evolves from an initial period during which trust is developed among group members through a period in which information exchange is the central activity, a period during which affective issues are addressed, and a termination period which parents are invited to attend. The program has been successful in convincing sexually active teenagers to use contraceptives and in allowing adolescents to explore their feelings about sexuality. 4 references.

81-1590
Pregnancy and Nutrition.
Society for Nutrition Education, Berkeley, Calif. National Nutrition Education Clearinghouse (NNECH).
Rev. ed. Berkeley, Calif., the Society (Nutrition Education Resource Series, No. 2), 15 p., December 1978.

Selected print and audiovisual materials are provided for persons teaching about pregnancy and nutrition, or counseling expectant parents. Items cited include books, pamphlets and leaflets, audiovisual materials, articles from professional and popular periodicals, and Spanish-language materials. All listings contain complete bibliographic information and current information for ordering. A title index is included.

81-1591
Sex Education of Children with Disabilities.
Symonds, M. E. and Wickware, L.
In: Sexual Consequences of Disability. Comfort, A., ed. Philadelphia, Pa., George F. Stickley Co., p. 243-247, 1978.

Sexual education for children with physical disabilities should be a lifelong process, beginning with counseling for parents. Early parental counseling should involve not only the physician but obstetric and pediatric nursing personnel and social service teams as well. The physician must maintain contact with the patient while the patient adjusts to the problem and obtains the necessary social service supports. Feelings of aversion that the parents may have about allowing their children to express normal sexual tendencies and feelings must be discussed and eliminated. The physician should instruct the parents in dealing with possible hereditary implications and in suggesting good planned parenthood principles to the children. Direct discussion of sex with the child during puberty should include information about alternative methods of intercourse, nongenital erotogenic areas, and other options. Ancillary literature and visual aids are helpful in these discussions.

81-1592
Teaching the Ethical Aspects of Sex Education: A Case Study Approach.
Wilkins, R. A.
Clearing House 52(5):223-226, January 1979.

The case-study approach to sex education refers to the study of specific situations in which a choice needs to be made between conflicting alternatives, enabling students to deal with the ethical and social aspects of their sexuality and sexual behavior. The approach fosters open group discussion of moral problems faced by the maturing adolescent and reduces the intervention of the teacher. Students can project their own dilemmas on the various cases and clarify values objectively within the group context. Case studies can be taken from novels, magazines, newspapers, or soap operas, or they can be contrived to meet special needs. Three case studies with accompanying questions to guide discussion are appended.

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BELGIAN HEART DISEASE PREVENTION PROJECT
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81-1486

CANADIAN BACK EDUCATION UNITS (CBEU)
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HERE'S LOOKING AT YOU
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STANFORD HEART DISEASE PREVENTION PROGRAM FIVE CITY PROJECT
81-1458

STANFORD THREE COMMUNITY PROJECT
81-1462

SUNAIR HOME FOR ASTHMATIC CHILDREN
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YOU AND YOUR HEALTH
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CURRENT AWARENESS IN HEALTH EDUCATION

DECEMBER 1982

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I

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INTRODUCTION

Current Awareness in Health Education (CAHE) is published monthly by the Center for Health Promotion and Education as a dissemination vehicle for the growing body of information about health education. It includes citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents acquired and selected by the Center. CAHE also contains descriptions of programs in health education. These descriptions are prepared from information that is provided by the programs themselves or found in directories, newsletters, and similar sources. To make the information in CAHE timely, only documents published or programs of relevance since 1977 are included.

Copies of each document and supporting documentation for each program description are stored in the Center's permanent collection. Users of CAHE are urged to consult local public, medical, and university libraries for individual copies. Sufficient information is provided in the citations to enable users to locate copies or to contact programs.

All persons receiving CAHE are invited to contribute copies of pertinent documents and descriptions of relevant programs for possible inclusion. The Center also welcomes any comments on CAHE and suggestions to improve its usefulness. Write or call:

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Education
Building 14
Atlanta, GA 30333
(404) 329-3235
FTS 236-3235

Tearsheets for submitting program documents and descriptions of relevant programs are provided on pages vii-viii.

IV

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HOW TO USE CAHE

CAHE contains two types of records: informative abstracts of published literature and descriptions of ongoing programs. These records are arranged in chapters according to their major subject area. Chapter headings are used to group items generally related and include: Community Health Education; Health Education in Occupational Settings; Health Education Methodology; Patient Education; Professional Education and Training; Regulation, Legislation, and Administration; Research and Evaluation; Risk Reduction; School Health Education; Self-Care; and Sex Education. The chapter headings reflect active areas in health education as well as major interests of the Center for Health Promotion and Education. To locate specific items of interest, users are encouraged to use the extensive Subject, Author, and Program Title indexes found in the back of each issue.

Within each chapter, citations and abstracts of documents appear first, followed by descriptions of programs. Abstracts with their citations are arranged in alphabetical order by the primary author's name, and descriptions of programs are arranged in alphabetical order by the title of the program.

Each document and program description has a unique accession number. Accession numbers of documents consist of a two-digit prefix indicating the year of acquisition by CAHE and a four-digit number indicating the publication sequence of the document. For example, 79-0022 indicates the 22nd document acquired by CAHE in 1979. Program accession numbers have a similar format with a "P" added following the year to indicate program, e.g., 79P-0025 indicates the 25th item acquired by CAHE in 1979, and that the item is a program.

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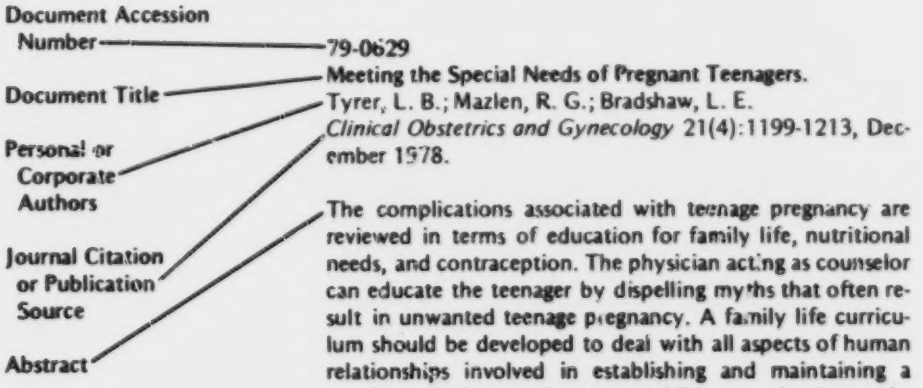
Document Accession Number
79-0629
Document Title
Meeting the Special Needs of Pregnant Teenagers.
Personal or Corporate Authors
Tyrer, L. B.; Mazlen, R. G.; Bradshaw, L. E.
Journal Citation or Publication Source
Clinical Obstetrics and Gynecology 21(4):1199-1213, December 1978.
Abstract
The complications associated with teenage pregnancy are reviewed in terms of education for family life, nutritional needs, and contraception. The physician acting as counselor can educate the teenager by dispelling myths that often result in unwanted teenage pregnancy. A family life curriculum should be developed to deal with all aspects of human relationships involved in establishing and maintaining a marriage. As they reach puberty, children need to be taught about themselves as sexual beings. Nutritional requirements of pregnant teenagers present special problems that call for a multidisciplinary approach to their definition and treatment. The risk for the pregnant teenager and the fetus is high; good prenatal management can reduce complications during the perinatal period. Teenage reluctance to inquire about contraceptives indicates the need for counseling on their use. The accessibility of birth control services is limited for teenagers, although most states have affirmed minors' rights to them. 36 references.

The distributor from which a document cited in CAHE is available to the public may be given as the last element in the citation. The most commonly cited distributors and their acronyms are listed below. Price information may be obtained from the supplier at the address given by specifying the order or stock number of the document and the form, hard copy or microfiche, desired. If the document is available from a distributor other than those listed, such as directly from the author, the address of that alternate distributor is provided.

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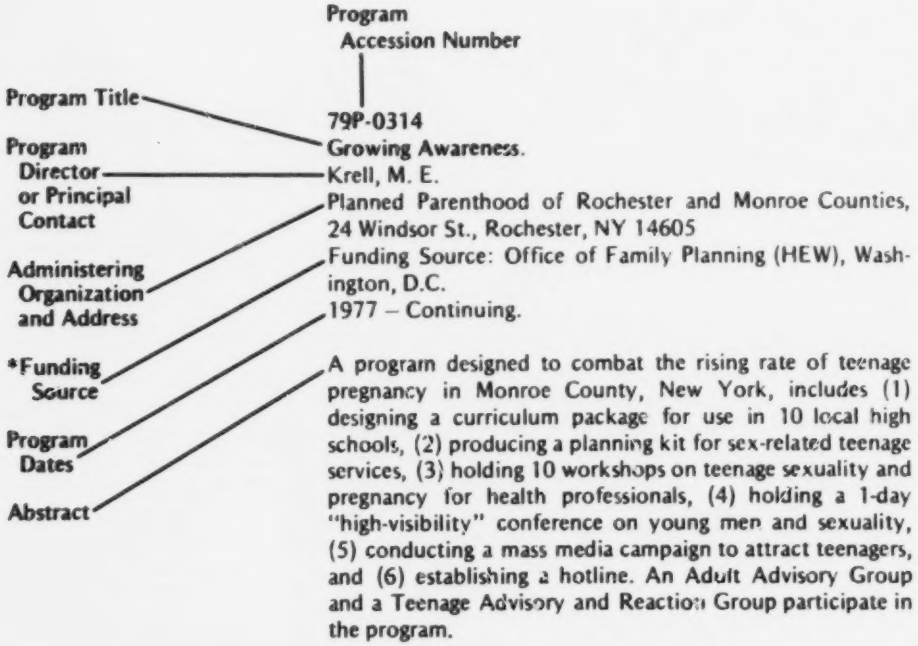
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Program Title
Program Director or Principal Contact
Administering Organization and Address
*Funding Source
Program Dates
Abstract
79P-0314
Growing Awareness.
Krell, M. E.
Planned Parenthood of Rochester and Monroe Counties, 24 Windsor St., Rochester, NY 14605
Funding Source: Office of Family Planning (HEW), Washington, D.C.
1977 – Continuing.
A program designed to combat the rising rate of teenage pregnancy in Monroe County, New York, includes (1) designing a curriculum package for use in 10 local high schools, (2) producing a planning kit for sex-related teenage services, (3) holding 10 workshops on teenage sexuality and pregnancy for health professionals, (4) holding a 1-day "high-visibility" conference on young men and sexuality, (5) conducting a mass media campaign to attract teenagers, and (6) establishing a hotline. An Adult Advisory Group and a Teenage Advisory and Reaction Group participate in the program.

CAHE contains three indexes. They are: (1) Author, which contains the names of personal and corporate authors of documents and directors of programs; (2) Subject, which contains subject descriptors, including geographic location, for both documents and programs; and (3) Program Title, which contains names of programs that are either mentioned in documents or detailed in program descriptions.

*The funding source is specified if the program receives funds from institutions other than the administering organization.

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PROGRAM DATA SHEET

The Center for Health Promotion and Education is collecting information about current health education programs for use in *Current Awareness in Health Education* and in analyzing program trends in the field. A program may provide identification, public awareness, coordination, training, demonstration, etc.

If you wish to share your program efforts with other health education professionals, please complete the form below, being as specific as possible in providing information.

We greatly appreciate your taking the time to share your experience with us.

---

1. Program Identification:

   Official Title of Program or Grant and Grant No: _____

   Official Name of the Organization Conducting the Program: _____

   _____

   Address of the Organization:

   _____
   street city state zip code

   Program Director: _____
   name title telephone area code number

   Principal Contact: _____
   (if different from Program Director) name title telephone area code number

   Beginning Date of Program: _____ Ending Date, If known: _____

2. Funding Source for Your Program:

   Please provide the Name(s) and Location(s) (City, State) of Funding Source(s):

   _____

   _____

   _____

3. Focus of Program: _____ Administration _____ Community Health Education _____ Health Education Methodology

   _____ Nutrition Education _____ Occupational Health Education _____ Patient Education

   _____ Professional Training Programs _____ Research and Evaluation _____ Risk Reduction _____ Sex Education

   _____ School Health Education Other _____

4. Target Population(s): _____

5. Purpose of Program: Please describe the primary purpose of your program

   _____

   _____

   _____

   _____

   _____

   _____

   _____

6. Publications/Information Materials: Please send copies of any publications or material describing your program, if available, or give complete citation (author, title, date, publisher). If no publications exist or are planned, please state how further information may be obtained.

   _____

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THANK YOU.

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COMMUNITY HEALTH EDUCATION

81-1593
Health Knowledge Assessment--A New Approach in Community Health.
Nursing Journal of India (New Delhi) 70(2):32, February 1979.

Community health nursing students from the graduate school of nursing in Indore, India, conducted an informal survey to determine the health needs of a local community. Informal conversations with 20 different households identified the following health problems: sanitation, eye diseases, typhoid, malnutrition, bone defects, inadequate health services, and fear of family planning. The residents were pleased that the students expressed an interest in their well-being and indicated that they wanted frequent and regular visits to their village.

81-1594
Notes for Students: Health Education in the National Health Service.
Hospital and Health Services Review (London) 74(3):110, March 1978.

An increasing emphasis on prevention and the influence of lifestyles on health has resulted in rising interest in health education within the British National Health Service (NHS). The Health Education Council, funded by the Department of Health and Social Security, conducts national health education campaigns and provides material for local services. In addition, many voluntary bodies, such as the Royal Society for the Prevention of Accidents, provide health education services. The reorganization of the NHS, based on the 1972 white paper, provided area health authorities (AHA's) with comprehensive health education powers in order to prevent illness. The AHA's inherited established health education services from existing local authorities or developed new services. Many AHA's appointed health education officers with nursing and health visiting or teaching backgrounds, and with degrees in health education. AHA's policies have stressed provision of health education in schools and universities and involvement of teachers and medical professionals in health education. Community-based primary prevention and hospital-based secondary and tertiary prevention services are provided as well. To enforce health policies and programs, AHA's employ a working team consisting of a medical adviser, a general practitioner, two nursing officers, and the district health education officer.

81-1595
Is Health Education for the Middle-Aged and Elderly a Waste of Time?
Anderson, W. F.
Family and Community Health 3(4):1-10, February 1981.

Planning health education services for the elderly in the United Kingdom involves developing diagnostic, preventive, and ascertainment services specifically designed for this target group as well as provisions for continual supervision of some individuals. Surveys of elderly populations indicate that there are many tolerated illnesses in the population at any one time. Higher pain thresholds, diminished mental capacities, and high levels of depression characteristic of elderly populations make diagnostic outreach efforts essential to any health care plan. In the area of prevention, elderly persons should be encouraged to exercise, eat nutritious foods and avoid malnutrition, participate in some sort of employment or vocation, and participate in educational activities. Preretirement courses addressing these issues have been held in Glasgow since 1959, and approximately 10,000 people have participated. Postretirement courses are also being offered upon request, and a part-time employment bureau was opened that has provided employment for 2,700 elderly persons since 1967. Finally, the Glasgow program provides home visitation to offer ascertainment services (which seek out illness at an early stage) and to ensure continuity of care. 20 references.

81-1596
Health Fairs.
Brown, G. E.
New York State Journal of Medicine 80(12):1878-1879, November 1980.

The Committee on Personal Health Services of the State of New York Public Health Council recently studied health fairs. Health fairs, sponsored by community organizations or business interests, serve as community centers for health counseling and education, information on health services, and screening services. The committee concluded that health fairs warrant support as means of helping people become part of the mainstream of medical care and motivating people toward improved health behavior. The committee recommended that (1) health fairs be regulated via a permit system so that laboratory tests can be performed; (2) health professionals upgrade the operation of the fairs by issuing guidelines, consultation, and technical assistance; (3) sponsors evaluate the

effectiveness of fairs on modifying health behavior and utilization of health services; (4) followup procedures be implemented for individuals requiring diagnostic or therapeutic care; and (5) the primary emphasis of health fairs be health education, not health screening.

81-1597
Tennessee Cooperative Rural Hypertension (1979).
Bryan, T. E. and Hanna, M. C.
Journal of the South Carolina Medical Association 76(9, Suppl.):87-101, September 1980.

The Tennessee Cooperative Rural Hypertension Project, funded by Merck, Sharp, and Dohme ($29,393) and the Tennessee Valley Authority ($5,000), was a 6-month effort to identify, educate, and refer for treatment all hypertensives in a four-county area of rural western Tennessee. Eight medical students and numerous community leaders participated in a 1-day orientation session before the program began. During the summer of 1979, two medical students in each county spent 8 weeks developing and implementing hypertensive control projects. Program activities, individually tailored for each community, included mass media educational programs, 175 presentations to community groups, professional education services, clinical screening and counseling, and referral and followup. Data collected during screening indicated that (1) 7,877 adults, or 11 percent of the total population of the 4-county area, had their blood pressure checked; (2) the screened population was 55 percent female; (3) 20 percent of whites and 26 percent of blacks were hypertensive; and (4) 6 percent of the identified hypertensives were under medication at followup. An assessment indicated that the program staff needed to spend more time in preparing the community and the students. Nevertheless, the program was effective and could easily be expanded.

81-1598
City Fit: How New Rochelle Keeps in Shape.
Curtis, J.
Parks and Recreation 15(12):29-34, 56, December 1980.

In 1977, the city of New Rochelle, New York, launched "City-Fit," a fitness and wellness campaign. The program stimulates community interest in wellness, offers public education about health and self-care, demonstrates free or low-cost means to achieve and maintain wellness, and conducts outreach services through park and recreation departments. Target groups include inactive children and adolescents, housewives, business executives, police and fire personnel, unemployed adults, the handicapped, convalescents, alcoholics and drug abusers, college students, elderly persons, and sedentary office workers. Physical fitness projects were developed specifically for each population. City-Fit provides services at malls, shopping centers, churches, open street areas, parking lots, centers for the elderly, nursing homes, and numerous other settings. Programs have included races, calisthenics, massage demonstrations, nutrition education, swimming programs, demonstrations of Eastern medicine, and cardiopulmonary resuscitation training. Physical components of the program include an 18-station fitness course located on a 0.7-mile jogging trail, pedal boats for use on lakes located downtown, a mobile unit, and exercise equipment. The program is publicized via radio, newspaper, leaflets, cable television, and demonstrations. Use of existing facilities has kept expenses low.

81-1599
A Model for Mental Health Education in Hispanic Communities.
Delgado, M.
Journal of Psychiatric Nursing and Mental Health Services 18(8):16-20, August 1980.

The Hispanic Program of the Worcester Youth Guidance Center in Massachusetts is a model for community-based mental health education. The program includes community education and training, clinical consultation, program consultation, research, and clinical intervention and case management. Hispanics believe that mental and physical functions are interrelated; changes in one produce changes in the other. This cultural concept of illness influenced the selection of the holistic approach for the delivery of mental health services. The program uses formal settings, including schools, child care centers, and churches, for short presentations on drug use, race relations, parent-child relations, and child development. Several presentations have been made in various community and human service settings. The program employs a multimodality approach that stresses group presentations, but it also uses radio and television broadcasts and films. Conforming to the schedules of community members, the program generally holds activities early in the morning or late in the evening. A needs assessment determined the high value placed by Hispanics on children; programs focusing on parenting, child abuse, and drug abuse are generally well received. Program planners of Hispanic mental health education services should conduct indepth investigations of Hispanic culture before planning, employ bilingual staff in the psychiatric nursing department, develop inservice training programs for Hispanic staff in formal and informal settings, and hire Hispanic paraprofessionals when possible. 25 references.

81-1600
Health Fairs.
Farrar, M. M.
Imprint 28(2):26, 53-54, 61, April 1981.

A health fair is an excellent way to involve students in the student associations of universities and colleges. Though an institution may use another health fair as a model, planning an original health fair allows participants to learn valuable principles of organizational leadership and extensive skills in developing and implementing such events. Health fairs coordinated by the National Health Screening Council for Volunteer Organizations always provide basic screening stations for health history evaluation, height and weight measurement, anemia assessment, blood pressure measurement, and measurement of visual acuity, as well as stations for summation of findings and referral. Initially, planners must pick a target group for screening, determine the size of the population, determine an appropriate location and the size of necessary facilities, and estimate the need for professional assistance and laboratory facilities. Development and promotion of the event should begin 2 months before the event. Committees should be established to deal with parking and site selection, finances, publicity, exhibitions, screening stations, preregistration and information requirements, summation and referral requirements, and followup of referrals. Sponsoring institutions should consider giving academic credit for participation in health fairs. 1 reference.

81-1601
Adult Health Conference: Community-Oriented Health Maintenance for the Elderly.
Furukawa, C.
Family and Community Health 3(4):105-121, February 1981.

The Adult Health Conference (AHC) program of the Boulder County (Colorado) Health Department was designed for ambulatory people 65 years old and above, although some people 55 to 64 years old participate as well. In 1972 the three-phase program began offering health care at recreational centers for the elderly. Nurses acted as observers. After this information-gathering phase, nursing services intensified, general health education and nutrition education was introduced, and a bilingual brochure on the program was published. During the next phase, a study to determine the need for AHC services in the city of Boulder was conducted. A positive response by city residents resulted in initiation of programs at a rent-subsidized housing project for the elderly and at a city recreation center. Services include health education and counseling, blood pressure screening, urinalysis, hemoglobin screening, medical care referrals, home visitation, and referrals to community agencies and other community resources. The program goal of reaching 1,200 people was exceeded in 1978. Both the screening and health maintenance components of the program proved successful. 19 references.

81-1602
Teachable Moments in Dentistry.
Green, S. M.
Ontario Dentist (Toronto) 57(8):22-23, August 1980.

A number of public health departments in Ontario, Canada, have started oral health education programs designed to take advantage of "teachable moments" (episodes or experiences that are good times for learning) of specific target audiences. The interest children show in dental health upon losing a tooth is exploited by a program that allows them to send the tooth to the "Tooth Fairy Society of Canada," in exchange for a dental health kit. Similarly, by sending box tops from low-sugar food cartons to the Dental Gum Massage Institute of Canada, adults receive a kit containing humorous signs for the bathroom and dental floss, a toothbrush, and pamphlets. A program called Infant Dental Medication provides new parents with a kit containing information on infant and early childhood dental health care. By capitalizing on teachable moments in these groups, the public health dentist has cooperated with the private practitioner to form an effective dental health education team.

81-1603
Health Care for Older Women: Toward a More Humanistic Approach.
Heiple, P. J.
Family and Community Health 3(4):51-59, February 1981.

There is a need to investigate the factors influencing the quality of care received by older women and to explore means of providing more wellness-oriented, humanistic health care for this group. Older women are more likely to have a chronic condition than older men are and are more likely to restrict their activity and to remain bedridden longer. Women's social roles place more emphasis on their health and allow them to assume the sick role with greater ease than men. Ageism, i.e., unintended negative feelings toward the elderly, has been exacerbated by Medicare and Medicaid policies. This trend is aggravated for older women by the sexist attitudes of some medical professionals. Most feminist programming deals with reproductive issues, neglecting the needs of older women.

If older women are to receive benefits from the recent emergence of holistic, humanistic health care, new programs must be aimed at helping them accept responsibility for their general health, nutritional status, and physical fitness; helping them manage age- and sex-related stress; and promoting environmental alterations that will help them cope with disabilities. 30 references.

81-1604
Genetic Counseling.
Herrmann, J. and Opitz, J. M.
Postgraduate Medicine 67(1):233-236, 238, 242-243, January 1980.

Genetic counseling includes collection of information, diagnosis, and communication of the facts to the patient or family. Current genetic counseling practices usually follow a team approach with a genetic associate, a pediatrician, a cytogeneticist, and perhaps a genetic biologist, a psychologist, a social worker, a mathematician, a developmental biologist, or physicians of various medical specialties. Often, nonprofessionals such as family members, friends, or those affected by similar conditions assist genetic counselors. The problems for which patients seek advice include blindness, deafness, mental retardation, birth defects, known genetic diseases, multiple occurrence of a condition in the family, infertility, shortness or unusual appearance, and consanguinity (close relationship by blood). Basic presuppositions of genetic counseling are discussed, including confidentiality, the integrity of the decision-making process, and an individualized approach. Emphasis is placed on collaboration between the counselor and counselee in examining consequences and options of therapy and reproductive choices, and on support for the efforts of the counselee in implementing decisions in areas such as social and nursing services, birth control, insurance and employment, and referral to relevant private and public services. The long-term effectiveness of genetic counseling may be assessed through measures such as the lifespan, prognosis, and earning power of patients; the cost of genetic conditions to individual families and to society; the frequency of defective genes; and the incidence of hereditary disorders and birth defects. 12 references.

81-1605
Implementing Preventive and Environmental Community Interventions.
Jason, L. A.
Evaluation and the Health Professions 1(3):85-93, October 1978.

An examination of community intervention programs that focus on, among other things, smoking prevention among high school students and reduction of smoking in public settings indicates that the most effective programs are those that build competencies and modify environmental irritants. A program involving three ninth-graders who wanted to stop smoking and two who wanted to resist peer pressure favoring smoking used seven hourly group sessions of discussion, role playing, and cognitive modeling. The small-scale effort was so effective that the model was implemented in two classes, where it was successful. In a public effort, posting of "no smoking" signs in public gathering places successfully reduced observed smoking levels in these areas. Community intervention programs will be successful if they adopt active stances in precipitating collaborations, overcome resistance to evaluation standards, and resolve discrepant expectations between academicians and laypersons. 11 references.

81-1606
A Community Health Education Program.
Madden, M. J. and Hanson, A. S.
Medical Group Management 28(1):38-39, January-February 1981.

A large multispecialty group practice, a bank holding corporation, and a community residents' group in the metropolitan Minneapolis, Minnesota, area coordinated a health awareness program, called Health Education Days, in three rural communities. Residents selected a significant health issue affecting their community and designed educational programs to increase the community's understanding and awareness of the health problem; the corporation and the group practice provided financial and technical assistance. Program development was undertaken by a 10- to 15-member committee of civic leaders organized by each community. The resulting "Alive and Aware" program included high school assemblies for discussion of health issues and physical fitness, sessions on modifying risk factors, talks on venereal disease, and provision of health education speakers at meetings of various community organizations. The group practice staff participated with local professionals to plan and direct workshops and develop additional programming. The programs were publicized via newspaper articles and advertisements, radio announcements, and brochures distributed by local banks. Data from evaluation instruments administered after educational sessions indicated that the programs were well received and provided suggestions for filling gaps in local health services.

81-1607
Physician and Hospital Involvement in Community Health Education.
Mamana, J. P.
Hospital Medical Staff 9(1):10-11, January 1980.

Public interest in good nutrition practices, physical fitness, disease prevention, and early detection of disease provides an excellent opportunity for hospitals to become involved in comprehensive health education and promotion programs. The American Hospital Association has established the Center for Health Promotion to help hospitals set up health education programs within the community. Local health programs should be aimed at specific local needs. Participation by hospitals and health care professionals in community health education programs will help contain health care costs and increase the prestige of involved institutions and providers. 2 references.

81-1608
Poison Prevention at Munson Medical Center.
Marvel, M.; Lillrose, B.; and Ellison, N.
Michigan Hospitals 14(11):40-41, November 1978.

The poison prevention program at Munson Medical Center in Traverse City, Michigan, consists of a 24-hour poison information line in the pharmacy and emergency departments and a school outreach program run by the hospital auxiliary. In its first year (1977), the outreach education program reached 3,000 children attending grades K-3. The program has extended its efforts to nursery schools, scout groups, and adult groups. The adult and child components attempt to acquaint participants with the prevalence of the problem, techniques for preventing poisoning, and procedures to follow when poisoning has occurred. The hospital's public relations office acts as liaison between the program and interested groups by assigning volunteers to conduct programs upon request. The children's program uses a cartoon filmstrip, a game involving empty bottles whose contents could be poisonous, and handouts; the adult program uses a film on the role of adults in preventing poisoning of children. Evaluations from teachers indicate that the program has been accepted favorably by the children.

81-1609
Health Education and Leprosy.
Matthews, C. M. E.; Selvapandian, A. J.; and Jesudasan, M.
Leprosy Review (London) 51(2):167-171, 1980.

A health education program conducted in the vicinity of Vellore in South India over 18 months was designed to provide information about leprosy and to motivate the public to act to control the disease and rehabilitate affected persons. Specific objectives of programming included motivating patients to present themselves for early and regular treatment, promoting the public's willingness to employ patients and to make harmless contacts with them, and developing patients' abilities to care for their hands and feet. A survey of the community's knowledge about and attitudes toward leprosy and of practical responses to the disease was undertaken before and after the intervention program. The program provided training to staff and village leaders, sponsored public meetings, presented films and slides, distributed leaflets, displayed posters, and held small group talks aided by flashcards. Leaders and regular patients were used to motivate those patients who were not taking regular treatment. Followup reminders were sent to patients who failed to report for scheduled appointments; treatment was given by proxy for patients who could not attend; and the leprosy clinic was run as a general skin clinic in one village. Survey data indicated that the program was a success. Resources necessary to implement a similar program for a population of 200,000 would include, in addition to leprosy unit staff, a health educator, a social worker, and 2 projectionists. The project should last 2 to 3 years, though projectionists would only be necessary for 6 months. 14 references.

81-1610
Health Education.
Neville, P. J.
Excerpta Medica. International Congress Series No. 466:-329-333, 1980.

Health education is increasingly becoming recognized as an essential element of leprosy control programs. Prejudice or discrimination against leprosy patients and indifference to the disease present challenges to those concerned with the social and educational aspects of leprosy control. Program development involves knowledge of the community and its leaders, identification of problems within the community as perceived by community members, establishing communication between the community and program staff, developing behavioral objectives, selecting appropriate educational media, and assessing educational activities. A leprosy education program should strive to prevent deformities and change community attitudes. Implementation of an effective program involves staff training that identifies beliefs and customs hindering patient compliance with treatment regimen, stresses communication skills, and encourages teaching methods appropriate to specific groups. Such a program will also involve reorganization of the leprosy clinic. 8 references.

81-1611
Questions About Cancer: Indicators for Patient Education.
Oleske, D.
Topics in Clinical Nursing 2(4):1-8, January 1981.

The Illinois Comprehensive Cancer Center recently conducted a study on the use of its Cancer Information Service (CIS) over a 3-year period (1976-79) to help identify the cancer education needs of the community. To transmit cancer information, the CIS uses television, radio, newspapers, brochures, and its telephone service. Two secretaries, one nurse, and two lay counselors staff the service, and all receive inservice training on health education and cancer. The service has one statewide incoming WATS line to complement its four local telephone lines. Information on each telephone inquiry is entered on coded forms and processed by computer. Analysis of the data indicates that (1) the number of inquiries grew from 1,729 in 1976-77 to 3,018 in 1978-79; (2) 11 percent of the calls were from previous callers; (3) female callers outnumbered male callers by three to one; (4) the frequency of questions concerning an anatomical site roughly corresponded to the incidence of cancer at that site; (5) the majority of callers asked about the location of resources for cancer treatment and followup; and (6) relatives of cancer patients represented the majority of callers. A questionnaire survey of 336 persons who used the service over a 10-week period indicated that (1) callers were of a high socioeconomic class; (2) men and ethnic minorities were underrepresented; and (3) written information is wanted and appreciated. 4 references.

81-1612
NET in a Child Care Center.
Serrano, T.
Food and Nutrition 9(6):18-19, December 1979.

The Chinatown Community Children's Center, a bilingual and bicultural child care center serving the predominantly Chinese population of San Francisco's Richmond District, provides a special nutrition education program for low-income preschool children. Less than 5 percent of the children speak English, and most neither recognize domestic foods nor remember their own native foods. Using songs, finger plays, cooking exercises, gardening experiences, and games, the program exploits the children's natural desire for activity. Plate-waste studies have indicated that the program decreases the amount of food wasted by children, and it appears that the program has improved the nutritional awareness of parents.

81-1613
Preventative Health: A Prescription for the 80's.
Sims, J.
Texas Hospitals 35(8):9-11, January 1980.

The Memorial Hospital System of Houston, Texas, instituted a School of Community Health Education to provide preventive health education courses for the public on a continuing basis at all three hospitals in the system. During the spring, existing health education courses designed for the public were surveyed and the operations of schools that offered nonprofit adult courses were examined. Finding that, both locally and nationally, such public health education services were uncoordinated, programmers consulted individuals involved in all areas of health to develop a consensus on adequate subject matter, instructors, and educational levels for courses. From January through August 1979, 13,394 questionnaires were distributed to Houston residents to determine health education needs. As a result, courses in stress management, emergency medicine, and nutrition were developed and advertised via 30,000 brochures and newspaper ads. After further evaluation of the initial survey data, course evaluation data from students, and other public responses, a full schedule of 20 courses was developed for the 1979-80 academic year. Twelve of the courses were initiated successfully, with an overall registration of 233 students.

81-1614
Inadequate Nutrition in the Elderly: A Stumbling Block to Good Health.
Skaien, P.
Family and Community Health 3(4):61-66, February 1981.

Changes in economic status, proneness to disease, lifestyle habits, and psychological outlook create barriers to good nutritional habits among the elderly. Diminishing ability to chew, digest, taste, and smell lessens the desire for certain foods; dehydration, irregular bowel movements, and laxative medications often interfere with nutritional processes. The cost of food, immobility, and misconceptions regarding proper nutrition create barriers to proper food choices. The need to alter dietary habits for therapeutic reasons can be traumatic for the elderly. Social isolation often results in the preparation of inadequate meals of commercially packaged food. Nutrition education, provided through individual counseling or in group sessions, can be effective in eliminating these barriers. Health providers should be aware of disease manifestations in elderly persons caused by poor nutritional habits and should be able to provide nutritional evaluation and counseling for cancer patients, patients with urinary infec-

tions, and patients who have trouble eating. Finally, many community outreach organizations are providing "Meals on Wheels" and similar nutritional outreach efforts to bring food to the elderly or the elderly to food. 5 references.

81-1615
Health Education in Clinic and Community: Some Experiences.
Stobart, R.
Australian Family Physician (Sydney) 8(3):256-258, March 1979.

The health education duties of a typical general practitioner (GP) in a community clinic in Ballan, Australia, include discussions with patients about smoking, drinking, weight problems, family histories, breast examinations, and smear tests. On the community level, the GP must (1) coordinate health education counseling committees to assist teachers, (2) improve school health education, (3) help families of children with health or social problems, (4) offer home visitation and counseling services, and (5) support the school nursing and dental services by following up on children referred by these services. The committee in Ballan, which includes a district nurse, nuns and a social worker from the Early Childhood Development Program, an infant welfare nun, a school nurse, a health inspector, and a GP, meets every 2 to 3 months. The committee has compiled an information register for teachers and a complete vaccination card for all schoolchildren in the area. Creation of a drop-in center for teenagers is being considered.

81-1616
Lifestyle Change in Elderly Hypertensive Persons: A Multifaceted Treatment Program.
Uman, G. C. and Hazard, M. A.
Family and Community Health 3(4):87-99, February 1981.

The West Side Senior Health and Counseling Center, a free clinic for the 22,000 elderly residents in Santa Monica, California, initiated a hypertension program aimed at (1) screening 2,000 elderly persons annually, (2) encouraging compliance with treatment regimens among identified hypertensives, and (3) teaching methods of integrating positive health behaviors associated with lowered blood pressure. Upon entering the program, the participant goes through (1) an intake process that includes collection of demographic information and determination of hypertension status; (2) a screening process based on accumulation of three blood pressure measurements; and (3) a counseling process that consists of individual care by a nurse, support for continuing contact with a private physician, and participation in appropriate group experiences. Review of the charts of the first 100 participants indicated that (1) the program was successful in having participants revisit the program; (2) 50 percent of the subjects who began the program with high blood pressure progressed into the acceptable blood pressure range; (3) an average of 7 pounds was lost by each obese participant; and (4) lifestyle changes did not uniformly correlate with blood pressure changes. 16 references.

HEALTH EDUCATION IN OCCUPATIONAL SETTINGS

81-1617
The Changing Requirements of Safety-Health Education in Industry; Remarks Prepared for the Southeastern Section of the Association for the Advancement of Health Education, Opryland Hotel, Nashville, Tennessee.
Blackmon, J. T., Jr.
Oak Ridge, Tenn., Union Carbide Corporation, Nuclear Division, 10 p., March 1, 1980.
Available from: NTIS; Order No. K-D-5075.

National legislation is encouraging industrial and commercial management to educate employees in safety and health. In response to these mandates, the Union Carbide Corporation instituted a corporate safety and loss control program that has reduced occupational injuries resulting in lost workdays among the 20,000 employees in the company's nuclear division to 0.3 injuries per 1,000 employees per year. This compares favorably with the U.S. average of 8.5 lost workdays per 1,000 employees. Unfortunately, the off-the-job injury rate for employees of the nuclear division is much higher than the on-the-job rate. The management-employee team that directs the safety program receives input from staff specialists, including the occupational physician, the occupational nurse, the industrial hygienist, industrial safety specialists, radiation control specialists, the fire protection specialist, the toxic material release specialist, the mechanical equipment-testing specialist, and engineering designers. These experts also act as occupational health and safety educators for employees and managers. Numerous inhouse safety and health education programs are conducted in a measurable way through the use of the staff specialists. Educational programs should integrate principles of occupational safety and health within high schools, colleges, and the continuing education system. 10 references.

81-1618
Outcome Evaluation and Accountability in Corporate Fitness Programs.
Dedmon, R. E.; Kubiak, M. K.; and Konkol, P. D.
Neenah, Wis., Kimberly-Clark Corporation, 22 p., October 3, 1979.
Available from: ERIC; Order No. ED-191 820.

Findings from a 2-year study of the Kimberly-Clark Company's Health Management Program are presented in tabular and graphic form. Areas of the fitness program examined include facility use, program participation, infirmary visits, and alcohol and drug abuse counseling. Over 90 percent of the employees have had multiphasic screenings and exercise tests; 50 percent have attended exercise orientations; and 25 percent currently use the exercise facilities.

81-1619
Health Education in the Workplace.
McEwen, J. and Randell, J.
Occupational Health (London) 32(10):515-516, October 1980.

In the United Kingdom, 1 million people per month receive sickness benefits for work-related and non-work-related maladies. As a result, health education at the worksite has gained increased attention as an important facet of the workday. To deal with the need for occupational health education, the Health Education Council convened a consultative group and a 2-day workshop. The objectives of the workshop were to identify for occupational health workers the role of health education in their professional practice, the concept of health education currently held by occupational health practitioners, and practical strategies by which health education activities can be identified. Workshop delegates included occupational health nurses, industrial physicians, instructors of occupational health courses, health education officers, and a Trades Union Congress representative. A report of the proceedings of the workshop has been published; it suggests the development of an enhanced consultative group, distribution of the report to the broadest feasible audience, use of the report by practitioners and trainers as a trigger for discussion, and implementation of the recommendations developed during the workshop. 2 references.

81-1620
Safety Training Methods.
Revelle, J. B.
New York, Wiley, 248 p., 1980.

Guidelines for implementing a hands-on approach to safety education in occupational settings are provided for use by employees, supervisors, and managers. Topics include integration of safety training, the instructional sequence for job training, Occupational Safety and Health Administration (OSHA) requirements, the supervisor's role in safety training, recordkeeping, specific safety-training techniques, fire safety training, OSHA inspection training, identification of housekeeping violations, unsafe conditions involving mechanical or physical facilities and other obstacles, hazard inspection training, medical and first aid training, and evaluation of safety-training effectiveness. Appendices include a glossary of pertinent terms, a discussion of a model safety program, a list of service organizations and associations, a list of regional offices associated with the Office of the Solicitor of the U.S. Department of Labor, a list of regional offices of the Bureau of Labor Statistics of the Department of Labor, a bibliography of pertinent publications and periodicals, and a list of specific sources of safety information and data analysis.

81-1621
Physiological and Attitudinal Changes in Those Involved in an Employee Fitness Program.
Rhodes, E. C. and Dunwoody, D.
Canadian Journal of Public Health (Ottawa) 71(5):331-336, September-October 1980.

Seventy male volunteers employed by the Finning Tractor Corporation, a company based in Vancouver, Canada, were studied to assess the feasibility of establishing an exercise program in an industrial setting. All 70 volunteers were pretested on physiological parameters by a team from the Department of Physical Education at the University of British Columbia. Forty of these subjects participated in a 6-month exercise program, and 14 subjects were used as a control group. Postprogram tests included a repetition of the physiological assessment and a questionnaire administered to the exercise group to identify psychological changes and other effects. Data from the tests indicated that (1) body weight decreased significantly among those in the exercise group, while the average weight of those in the control group increased; (2) the average pulse rate of participants in the exercise group decreased, but remained constant for the control group; (3) vital capacity and maximal breathing capacity improved significantly for the exercise group, but only slightly for the control group; and (4) most participants in the exercise group thought the program benefited their work and personal lives. 19 references.

81-1622
Industrial Hypertension Control Program in a Rural State.
Walworth, C. C.
Journal of the South Carolina Medical Association 76(9, Suppl.):75-82, September 1980.

The New Hampshire Blood Pressure Control Program, which took place between 1973 and 1976, focused on 47 industries in 18 different communities located in the southern part of the State. A mobile blood pressure team screened 60 employees per hour during working hours, and a full-time secretary maintained an office in Concord. Employee screening involved a medical-history questionnaire, measurement of weight, measurement of resting blood pressure, and two followup blood pressure measurements for all hypertensive employees. All hypertensives received counseling and further testing. Meetings were held with hospital staffs to report results, and all hypertensives received followup calls 2 and 6 months after screening. Of the 22,776 employees in the target area during the program's first year, 69 percent participated. Eighty percent of identified hypertensives were still under treatment by their physicians 6 months after screening, but physician followup of referrals was found to be somewhat inadequate. Findings of the second year support these findings.

81-1623
"Heartifacts": A Pilot Project in Nutrition and Cardiovascular Disease Education.
Weaver, S. and Fedyck, H.
Journal of the Canadian Dietetic Association (Toronto) 41(4):310-315, October 1980.

"Heartifacts," a program of nutrition education for cardiovascular disease prevention, was tested in Kent County, Ontario, Canada, on 3 groups of approximately 33 employees each from local industries. One group was exposed on the job to nutrition information over a 12-week period by means of posters, newsletters, and bulletin boards. A second group in the same employment setting was exposed to the same information as well as a noon-hour series of educational sessions presented by the nutrition coordinator of the project. The third group, located in a different employment setting, served as a control. All three groups completed a questionnaire before and after the program; the questionnaire gathered information on risk factors in the participants' lifestyles and their knowledge about diet and cardiovascular disease prevention. Preprogram test results indicated that the three groups had the same level of nutrition knowledge; postprogram test results showed a significant change in knowledge for members of both intervention groups, regardless of age, sex, or educational level. The control group experienced no significant knowledge gain. 4 references.

81P-1624
Cannon Mills Company Cancer Education and Screening Program.
Heyden, S. and Fodor, J. G.
Duke University Medical Center, Department of Community and Family Medicine, Box 2914, Durham, NC 27710
Funding Source: National Cancer Inst. (DHHS, NIH), Bethesda, Md.
February 1976-January 1978.

The Cancer Education and Screening Program at the Cannon Mills Company in North Carolina was designed to educate and screen employees for high blood pressure, diabetes, and cancer. One-hour group lectures, each with 50 participants, were presented on company time. Audiovisual materials (40 color slides and short videotapes) were used to give concise epidemiologic and clinical information on a variety of cancers, early signs and symptoms, and procedures used for early detection. A nurse and a Duke University Medical Center employee gave lectures and instruction in self-examination. Technicians and aids assisted. Among 13,126 employees screened at 6 cancer sites, cancers were found in 33. Seventy percent of these 33 were still working full time as of September 1979, and only 4 patients (12 percent) had died. The prevalence of hypertension ranged from 15 to 16 percent in white females and males and from 16 to 22 percent among black males and females, respectively. Of 144 people testing positively for diabetes, only 11 did not follow advice to see a physician. The cost of screening amounted to $10 per person. The cost of a case finding was calculated for one prostate cancer ($962), one breast cancer ($1,584), and one cancer of the uterus ($1,476) by multiplying the cost of one screening examination by the number of participants in the particular test and then dividing by the number of cases detected.

HEALTH EDUCATION METHODOLOGY

81-1625
Handbook for Counseling Patients on Their Medications: One of the Principal Responsibilities of the Health Care Practitioner.
Apelgren, S. E. and Rowles, B.
1st ed., updated. Hamilton, Ill., Drug Intelligence Publications, 166 p., 1978.

A reference digest of medication counseling information is provided for use by health care practitioners. Most sections contain a general discussion of the therapeutic class as a whole. Medications covered include analgesics, antipyretics and antirheumatics; anorexiants; antacids; antiasthmatics; anticholinergics and parasympatholytics; antidepressants; oral antidiabetics; antidiarrheals; antiepileptics; antihistamines and antihistamine combination products; antivertigo and antiemetic drugs; blood modifiers; cough mixtures; diuretics; enzymes; hormones; laxatives; antimicrobials; muscle relaxants; nutritional agents; penicillins; psychotherapeutic agents; sedatives and hypnotics; sulfonamides; tetracyclines; topical preparations and vaginal and rectal medications; vascular and cardiac agents; and eye, ear, and nose products.

81-1626
Drug Compliance: Some Aspects of Improving Compliance With Therapy in the Hypertensive Patient.
Brackett, N. C., Jr.
Journal of the South Carolina Medical Association 76(9, Suppl.):54-59, September 1980.

A review of the commonly accepted causes for lack of patient adherence to antihypertensive treatment regimens suggests remedies for improving compliance among such patients. The most commonly cited reasons for nonadherence include the asymptomatic nature of the disease, drug side effects and interference with established lifestyle, ignorance of the risks of uncontrolled hypertension, and socioeconomic disadvantages (cost of drugs, insurability, and employment). To overcome the resistance of hypertensives or potential hypertensives to adhering to therapeutic prescriptions, patient education conducted by physicians is necessary. Also, the strength and dosage of the drugs prescribed should be tailored to the patient's probable willingness to comply. Techniques of patient activation and periodic reassessment of drug needs and diagnoses of patients should be integrated into any such program. 11 references.

81-1627
Social Learning Theory and Behavioral Health Care.
Burns, K. L.
Psychotherapy and Psychosomatics 32(1-4):6-15, 1979.

As a result of rising health care costs and the lack of significant improvement in the health of Americans since 1950, many professionals have attempted to supplement the biomedical model with concepts from social-learning theory. Currently, only 2 to 2.5 percent of the outlay for medical care is spent on disease prevention and control measures. Hence, the individual's responsibility for preservation of good health is likely to become the center of attention in health promotion. A holistic view is becoming not only possible but imperative. Translating knowledge of health-destructive behaviors into action will require activity at many levels, including the administrative, political, and legislative. Social-learning theory can be used to elucidate the means by which behaviors are learned and by which their performance is effected through the social environment. Learning theory concepts, such as modeling and social reinforcement, have been applied successfully in health promotion efforts. Specific projects in which social-learning theory has been successful include the Cardiac Risk Reduction Project of Stanford University, a self-care program for diabetic patients at the University of Southern California, and a skills-training program for families with asthmatic children at the National Asthma Center. Future research in the field of social learning should concentrate on communication of knowledge of the effects of behavior on health, use of public media to alter behavior patterns, and cultural and social processes that influence people verbally and nonverbally. 15 references.

81-1628
Towards an Educational Model of Health Visiting.
Castle, A. J.
Health Visitor (London) 53(1):9-10, January 1980.

The role of the health visitor is teaching and helping individuals or families to cope with and solve their immediate and future health problems. The problem may be uncertainty related to behavior; insufficient knowledge to accomplish an appropriate action; or affective behavior such as anxiety, fear, hostility, rejection, or guilt. A progressive educational model approach should begin with client-defined or self-defined problems. The health visitor works to facilitate expression of the client's perception and personal definition of problems. The values incorporated in this model are humanistic and stress individuality. Based on the problem-solving process developed by learning and social learning theorists, the model proceeds from identification and assessment of problems, to development of objectives and formulation of a response via an educational intervention, to evaluation of the efficacy of the response. 6 references.

81-1629
Roots: Applications of Our Past 30 Years to Current and Future Health Practice: Keynote Panel, the SOPHE Annual Meeting, October 18, 1980--Introduction.
Deeds, S. G.
Paper presented at the 30th Annual Meeting of the Society

for Public Health Education, Detroit, Mich., October 1980, 7 p., October 18, 1980.

A look into the future of the health education profession indicates that it must make humanistic advances in theory, methodology, and practice. Like many other disciplines, health education has been and will be attempting to synthesize technological and humanistic approaches. Futurists are divided over which approach should predominate, but health educators realize that the optimum approach would balance the two alternatives. Health educators must acknowledge the emotional, intuitive, existential, and humanistic aspects of life to mitigate the ill effects of the scientific, mechanistic approach taken by Western medicine. 7 references.

81-1630
Set Up a Media Exchange.
Early, L. and Heider, M.
Health Care Education 6(6):17-19, December 1977.

A daylong event was conducted in Cincinnati to create a network of media resource people within Ohio. Development of the event involved establishing contacts with several Ohioans known to work with patient education and consumer education media, forming an ad hoc committee to establish a network from the contacts and to organize a work schedule, implementing a mail survey of all area hospitals, and acquiring funding from the Corporation for Health Education in Appalachian Ohio. Presentations on the day of the program addressed the importance of patient education and consumer health education, the use of printed materials to stimulate good health practices at the local level, closed-circuit television in hospitals, and low-cost educational materials for use in the inner city. A media fair filled three large classrooms with exhibits of media materials useful in patient education, and a panel of third-party payers stated their positions on reimbursement for patient education. Three workshops were developed around topics suggested by the 108 responses to the hospital survey. Workshop participants were instructed in the practicalities of hospital media projects. Evaluation forms obtained from 77 of the 131 registrants indicated that the event was valuable as a means of establishing network linkages and exchanging practical information. A followup assembly may be held, and the ad hoc committee will publish a newsletter or otherwise devise means to keep the network intact.

81-1631
Patient-Health Education: The State of the Art.
Gardner, H. H.
In: Patient-Health Education: The Librarian's Role. Proceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 1-7, 1979.

Because the medical establishment has little incentive to allocate funds for health education and is trained in tertiary rather than primary care, medical care delivery and medical practice should be separated from health care and health care issues. Librarians and health educators should look at health education from a nonmedical perspective, with concern primarily for behavior modification; they should focus on health issues rather than on participation in the medical care process. As librarians move into a more active health education role, they should (1) protect consumers from unnecessary medical care, (2) be prepared to function as consumer advocates in protecting people from medical channels that may be hazardous to their health, and (3) seek financing for services delivered in a direct way, rather than an accessory way. Libraries are sources of information that may prove to be an effective mechanism in dealing with behavior modification and education. This resource needs to be structured, organized, adequately funded, and independent of hospitals if libraries are to become an effective component of a health education program.

81-1632
The First Twenty Years of SOPHE: Health Education Practice, 1950-1970.
Griffiths, W.
Paper presented at the 30th Annual Meeting of the Society for Public Health Education, Detroit, Mich., October 1980, 24 p., Obtober 1980.

A review of the first 20 years of the operations of the Society for Public Health Education (SOPHE) indicates the diversity of tasks performed by SOPHE and SOPHE members. Its presidents have included an assistant to the president of the National Foundation for Infantile Paralysis, a chief of the Division of Public Health Education of the U.S. Public Health Service, a chief health educator of the San Jose City Health Department, a chief of the Bureau of Health Education of the California Department of Health, and an associate professor in health education at the Harvard School of Public Health. SOPHE and SOPHE members have been active in professional education, health education programs related to specific diseases, and publication of health education periodicals and books. Early on, SOPHE members were interested in community organization and decision making, sociological approaches to health education, mass communication, and group dynamics. During the 1950's, interest grew in the Health Belief Model, cultural anthropology, Maslow's theory of

motivation, community organization to deal with specific health problems, and development of public health education graduate schools. During the 1960's, planned change and social activism predominated. The Comprehensive Health Planning Act of 1966, which emphasized consumer participation, became the focus of the decade's activities and spawned regional medical programs and health education efforts associated with provision of Medicaid and Medicare benefits, family planning programs, and heart and cancer disease control programs. 66 references.

81-1633
Hows and Whys of Patient Contracting.
Herje, P. A.
Nurse Educator 5(1):30-34, January-February 1980.

Involving patients in goal setting through contracting is an effective way for nurses to help patients achieve positive health care outcomes. A contract consists of mutually agreed upon behavioral goals for the patient and the patient educator. Contracting gives patients an active role in their own care and defines patient and professional responsibilities. Contracts may be used with patients of all ages and in all settings; however, contracting is precluded when patients have minimal cognitive skills, lack the desire to become active participants in their own care, project responsibility for health matters outside themselves, or are in a medical emergency. Training nurses in contracting techniques requires improving their interviewing and evaluation skills, and setting realistic, measurable, positive, time-dated, and rewardable goals. Educational methods used in nursing education include role playing, observing contracting sessions, contracting with peers, and taping and simulating contracting situations. Evaluating the effectiveness of patient contracting is difficult because contracts are individualized. To determine the efficacy of contracting, more scientific and long-term followup is needed. 7 references.

81-1634
Pre-School Potential: A Health Educator's Perspective.
Hindson, P.
Australian Journal of Early Childhood 4(3):7-12, September 1979.

To mobilize parents and teachers to meet the health education needs of preschool children, the health educator must understand methods of effective programming. The educator should conduct informal discussions with parents to encourage the formation of a parent group, arrange an initial meeting on the basis of information elicited during the discussions, present a model program for consideration and discussion, and conduct a participant-oriented program. For many parents and preschool children, such programming will be their first opportunity for community involvement and will introduce them to concepts of group wellness and self-help interventions. For such programming to be effective, participants must trust the facilitator, help identify target problems, participate in planning and implementing program interventions, believe that programming will benefit themselves, adapt programming to their lives, and recognize the program as their own. 13 references.

81-1635
A Food Guide for the UK.
Kohn, F.
Journal of Human Nutrition (London) 33(1):75-78, 1979.

A simple, reliable, and officially recognized food guide is needed in the United Kingdom to provide uniform, accurate, and consistent information for those involved in nutrition education and to translate the recommended daily intake of nutrients, established by the Department of Health and Social Security, into practical language. The food guide should recommend a balanced diet through daily selection of items from each of a number of food groups; information on number and size of servings may also be included. The guide must be based on a realistic method for grouping foods; three methods currently used in the United Kingdom are based on nutrients, food functions, or basic foods. The nutrient grouping system, which classifies foods as protein, fat, carbohydrate, vitamin, or mineral, seems far too complex for use with the lay public. The system based on food functions categorizes foods as those needed for body building and repair, energy and warmth, and protection. This system, used in primary schools, gives the erroneous impression that a certain food performs a single, isolated function. The basic-foods grouping places foods under these headings: milk and milk products, meat and alternatives, vegetables and fruits, and bread and cereals. A four-food-group plan is used throughout Canada and the United States. It appears that the most practical method of grouping foods, with particular reference to developing a food guide, is under food headings. Foods included in the guide should be readily available, commonly consumed foods, and quantitative guidelines for consumption should be provided. An addendum to the guide should discuss moderation in eating; the use of foods rich in vitamin D and dietary fiber; restriction of fat, sugar, and salt intake; and the need for vitamin D supplements among children, pregnant and nursing mothers, and the homebound elderly. 16 references.

81-1636
Reducing Burnout in the Hospice and the Death Education Movement.
LaGrand, L. E.
Death Education 4(1):61-75, Spring 1980.

Cognitive modification (adjusting attitudes toward problems), exercise, relaxation techniques, and stimulus control are the major techniques for reducing the stress affecting professionals working in hospices and in the death education movement. When dealing with stress, a person proceeds from an alarm reaction through a resistance stage, to a stage of exhaustion unless the stress can be relieved before adaptive capacity is depleted. To ensure that professional staff can deal effectively with stress, hiring practices in institutions that deal with the dying should screen job applicants to identify those (1) motivated to serve others, and (2) able to relate well to others, and who are sensitive to human needs in specific situations, experienced in dealing with stress, and possessed of realistic and goal-oriented work habits as well as physical and psychological vitality. Cognitively, health team members should help each other set limits, release emotional pressure, modify negative self-judgments, and build strong interpersonal relationships. Regular physical exercise and relaxation techniques such as Benson's relaxation response or Jacobson's progressive technique, yoga breathing exercises, autogenic training, biofeedback, countdown, and transcendental meditation can release stress effectively. Management of stress through identification and alteration of stressful stimulus has been undertaken successfully by many health professionals. 18 references.

81-1637
New Media Techniques for the Nutrition Program.
Mercado, C. M.
Philippine Journal of Nutrition 30(4):150-156, October-December 1977.

Experience with the 5-year Population Communication Project in the Philippines suggests that involvement of the indigenous population in grassroots planning is vital to the success of any program involving numerous media. Nevertheless, "participatory planning" is rarely implemented because (1) programmers believe that rural people have no concept of planning or have no planning skills; (2) few fieldworkers have adequate skills in implementing participatory planning; and (3) programmers and fieldworkers do not realize the technical or social prerequisites of program implementation. Future campaigns, particularly nutrition education programs, should use folk media; give greater attention to males as targets of nutrition promotion; use videotape recording techniques; harness the concepts, perceptions, and beliefs of the target audience in developing communication materials; increase the amount of illustrated material by using comic book formats; use realistic literature as opposed to caricature literature; encourage group participation after use of electronic media; and encourage audience participation in developing media materials. 8 references.

81-1638
Pretesting in Health Communications: Methods, Examples, and Resources for Improving Health Messages and Materials.
National Cancer Inst. (DHHS, NIH), Bethesda, Md. Office of Cancer Communications.
rev. ed. Bethesda, Md., the Office (NIH Publication No. 81-1493), 46 p., November 1980.

Methods and resources for implementing needs assessments and other pretesting efforts are provided for use by health communicators. Pretesting for the health communication process is discussed in terms of planning and strategy selection, concept development, message execution, implementation of the communication process, assessment of in-market effectiveness, and assurance of feedback for revision of planning and strategy selection. Methods discussed include readability testing, focus group interviews, individual interviews, central location intercept interviews, self-administered questionnaires, the Health Message Testing Service system, and gatekeeper review. Planning and conducting pretesting research is discussed in terms of understanding the limitations of pretesting, designing a questionnaire, recruiting respondents, recruiting interviewers, arranging for facilities, and obtaining research assistance. Appendices include standard questions used by the Health Message Testing Service, estimates of direct costs for pretests developed by commercial research firms, a list of pretest reports available from the Office of Cancer Communications, a glossary of pertinent terms, and a bibliography. 50 references.

81-1639
Breast Cancer: Resource Guide 1.
National Women's Health Network, Washington, D.C.
Washington, D.C., the Network, 69 p., 1980.

Guidelines for developing breast cancer education programs are provided. Topics include the problem of breast cancer, breast self-examination, the controversy over mammography X-ray screening, a gentle approach to breast cancer education, and the experience of one woman who had mutilative surgery. Lists of comprehensive

cancer centers, bibliographic materials, audiovisual aids, resource people and groups, and general resources on women and health are appended.

81-1640
Health Education--Physical Dimensions of Health: Nutrition Education, Grades 7-9.
New York State Education Dept., Albany. Bureau of School Health Education and Services.
Albany, N.Y., the Department, 97 p., 1980.
Available from: ERIC; Order No. ED-191 846.

Guidelines for implementing a nutrition curriculum on the school district level or for planning lessons at the classroom level are provided for administrators and instructors. Topics for which teaching and learning strategies are provided include the effects of nutrition on health, adolescent growth and development, nutritional status, assessment of dietary adequacy, adequacy of teenagers' diets, factors affecting body weight, health implications of obesity, weight control, and nutritional health and the environment.

81-1641
Pick and Choose: A Videotape Series on Nutrition for Migrant Families (Coja y Escoja: Peliculas Para Television Sobre la Nutricion Para las Familias Migratorias.
New York State Education Dept., Albany, Bureau of Mass Communications.
Albany, N.Y., the Department, 34 p., March 1979.
Available from: ERIC; Order No. ED-171 488.

Guidelines for using "Pick and Choose," a series of three videotapes on nutrition, are presented for use with migrant workers. The program covers the nutritional needs of migrants and shows migrants as they live, shop, cook, and eat. The food suggestions take into account their tastes and traditional foods. Program I covers types of foods, nutrients, healthful snacks, and safe food handling. Program II covers various shopping methods, food labels, unit pricing, bargain hunting, complementary proteins in the diet, and foods as a source of energy and well-being. Program III covers weight control, snack food, and low-calorie snacks. Presented in a fast-paced format, the program is available on broadcast tapes, videotapes, and 16mm film. The guidelines explain the nutritional information offered in the series, list recipes and activities for adults and children, provide handouts, and list resources for more information.

81-1642
Preventive Group Interventions for Elderly Clients: Are They Effective?
Nickoley-Colquitt, S.
Family and Community Health 3(4):67-85, February 1981.

Eighteen group interventions involving an elderly population or members of families of the elderly were reviewed. The central strategies used by the groups concentrate on socialization, problem solving, social competency, social support, life crisis support, group counseling using peer counselors, well-being counseling, actualization and growth exploration, interpersonal skill training, expressive psychotherapy, personal growth support, preventive support, growth encounter, and resocialization. A variety of health workers conduct the groups, including social workers, psychiatrists, psychologists, and nurses. All groups focus on common developmental or situational stresses. Health education techniques include reminiscence, relaxation, task sharing, and problem solving. The groups also focused on providing the elderly with the ability to control their lives. Though the group framework, involving needs assessment, support, control, and change factors, seems effective, serious evaluation schemes have rarely been implemented. A tabulation of the results of the review is included. 17 references.

81-1643
Genetic Counseling for Adoptees at Risk for Specific Inherited Disorders.
Omenn, G. S.; Hall, J. G.; and Hansen, K. D.
American Journal of Medical Genetics 5(2):157-164, 1980.

A review of five cases, in which family histories were taken after a child's adoption, showed that the child was at 50 percent risk for inheritance of Huntington's disease, myotonic dystrophy, Fabry disease, von Willebrand disease, or Waardenburg syndrome. In each case, the biological mother requested that the genetic counseling provided for them and their children be shared with the adoptive family. The decision to seek the adoptee was based upon explicit assessment of the potential benefits and potential difficulties involved in contacting the adoptive families and in attempting to provide genetic counseling. Counselors dealing with families, who have similar separation of relatives by adoption, should follow as much as possible the wishes of the patient and guardians who originated family contact with the counselor or clinic, require explicit affirmation by responsible staff that the likely benefits of seeking the adoptee will outweigh the hazards of direct or indirect contact with the adoptive

family and the adoptee, ascertain the most desirable method of locating the adoptee and decide who will make the contact, assess the timeliness of contact, devise a method to insure confidentiality, and document discussions and actions at each step. 11 references.

81-1644
Five Things Not To Do When Making Patient Videotapes.
Rigg, J.
Health Care Education 8(4):22-23, August-September 1979.

An advisory committee, comprising representatives from the education department, nursing services, medical staff, and hospital administration, should approve all patient education videotapes. All actors, cameramen, and other production crewmembers must be thoroughly familiar with the script before filming. Actors should be selected carefully and instructed in proper delivery. Equipment should be checked before shooting to assure that malfunctioning does not delay the production schedule. Finally, all tapes should be cataloged and filed in a media library.

81-1645
Guidelines for the Use of Audio Visual Aids.
Rosenthal, S.
Ontario Dentist (Toronto) 56(8):18, August 1980.

Dentists should use creative, attractive audiovisual aids for effective counseling. Although the producer of the program must recognize the educational objective of improving oral health, the audiovisual presentation should not be overly serious or bookish. Presentations should be brief and direct, since the average patient's attention span is 10 minutes. The audiovisual unit should be located where treatment takes place to ensure that the patient identifies the educational experience with the treatment.

81-1646
The Layman's Need for and Access to Health Information: A Social Work Perspective.
Rusnack, B. L.
In: Patient-Health Education: The Librarian's Role. Proceedings of an Invitational Institute, February 5-9, 1979. Larson, M. T., ed. Detroit, Mich., Division of Library Science, College of Education, Wayne State University, p. 28-37, 1979.

The layperson's need for and access to health information is discussed. Education is a transactional process in which behavioral change takes place, and clients should be perceived as the producers of their own health care. To select, acquire, and disseminate information, librarians must be aware of the characteristics of the people who are seeking and using the information, the situations which bring them to the library for information, and the interaction that takes place between the person seeking information and the person providing information. How people use library services depends on several variables: (1) the people themselves, in the roles of patients, family members, or consumers; (2) their perception of health and health care, as determined by social background, culture, hierarchy of needs, stage of life, and place in the health-wellness continuum; (3) the place of information dissemination, based on availability, accessibility, acceptability, and accountability; and (4) the process of giving and receiving help. Certain characteristics and conditions of health education are suggested for further exploration. 10 references.

81-1647
The Potential of Health Education. (Editorial)
Smith, J. P.
Journal of Advanced Nursing (Oxford) 5(1):1-2, January 1980.

The Tenth International Conference on Health Education, held in London in September 1979, attracted over 1,000 delegates from 70 countries. Points addressed by various delegates included recent cynicism about the effectiveness and cost effectiveness of health education, the need to emphasize the goal of health for all by the year 2000, the need to deal with the shrinking resources for health education, the need for health educators to be nonjudgmental teachers and role models of good health habits, the importance of health education as a means of improving the quality of living rather than increasing longevity, and the central importance of the nursing profession to any health education effort. 3 references.

81-1648
Performance Contracting in Health Education.
Sutherland, M. S.
Farmington, Maine, Dept. of Health Science, Univ. of Maine at Farmington, 8 p., 1979.
Available from: ERIC; Order No. ED-171 663.

Performance contracting offers many advantages over traditional grading methods. In designing performance contracts, the health educator must consider student knowledge levels, health interests, time intervals for course units, available resources, value structures of students and their parents, value structures of school ad-

ministrators, and perceived student abilities. The contract must outline the information that a student must learn, the means of demonstrating knowledge acquisition, and the degree of proficiency that the student must achieve to be judged successful. Various resource alternatives should be provided. Some disadvantages of performance contracting are discussed. 6 references.

81-1649
Drug-Alcohol Education Resource Catalog.
Virgin, H.
Dillingham, Alaska, BBRRC Press, 118 p., May 30, 1980. Available from: Alaska State Department of Education, Health Education Section, State Office Building, Pouch F, Juneau, AK 99811.

Annotated citations of educational aids and resources for use in drug and alcohol education programs are provided for use by health educators. Citations include films, filmstrips, slides, videocassettes, videotapes, audiocassettes, audiotapes, posters, pamphlets, papers, books, curriculum guides, resource organizations, and miscellaneous materials.

81-1650
Reintegration: The Slow March of Progress. Towards a Reality-Oriented Concept of Health Education.
Wilkening, W.
International Journal of Health Education (Geneva) 24(1):11-19, 1981.

To reintegrate the poorly integrated conglomeration of specialized health promotion and prevention efforts, isolated insights and activities intended to promote health must be organized into a total concept of social reality. A framework within which health promotion and education efforts can operate in a unified manner would incorporate a conception of an unbroken continuum of health that extends from perfect health to total invalidity, clear definition of goals and priorities in health education, a conception of appropriate types of learning in health education, a reconstruction of the subjective and objective in health aspects of reality as an entity, a focus on emotional energy and the importance of satisfaction of human needs, a definition of target groups in relation to their ability to deal with their needs, and an understanding of the context of the objective aspects of living conditions. The practical consequences of this conceptual reassessment for planning and practicing health education include the need to define priorities, choose approaches emphasizing prevention, aim at young target groups, approach learning as an integrated process, view individuals as social beings, use social modeling as extensively as possible, provide learning experiences in the context of real life situations, realize that conflicting interests are central to life, view health as a lifetime process, integrate media into interventions, achieve a balance between professional assistance and self-help, coordinate activities of the central government with regional and local activities, and promote international cooperation and information exchange.

PATIENT EDUCATION

81-1651
Preparation and Practice of Community, Patient, and School Health Educators. Proceedings of the Workshop on Commonalities and Differences, February 15, 16, and 17, 1978.
(Hyattsville, Md.), Health Resources Administration, Bureau of Health Manpower, Division of Associated Health Professions (DHEW Publication No. (HRA) 79-40), 72 p., 1978.

On February 15-17, 1978, a workshop was sponsored by the Division of Associated Health Professions of the Bureau of Health Manpower to gather health education practitioners to discuss the similarities and differences among health educators in the preparation and practice of community, patient, and school health education. The workshop addressed the parameters of the health education profession and the functions and preparation of health educators. At the conclusion of the workshop, participants recommended that (1) each member of the workshop disseminate workshop proceedings; (2) the planning committee for the workshop become the National Task Force on the Preparation and Practice of Health Educators; (3) the task force, including a representative from the Office of Education, be responsible for developing a credentials program; (4) the task force survey field practice, develop a concrete statement of the state-of-the-art of health education, outline an assessment of health educator competencies and performance criteria, and delineate a core of curriculum requirements; and (5) government programs and private agencies with health education components require staffing by qualified health educators. A directory of participants and an evaluation questionnaire are appended.

81-1652
Readability--Its Applicability to Education of Patients by Pharmacy.
Adams, R. C.; Smith, T. P.; Metts, J. K.; and Ross, J. W.
Hospital Pharmacy 14(11):654-656, 659-660, 662, November 1979.

A review of the literature on the applicability of readability testing to the development of educational materials on pharmacology reveals the importance of recognizing reading skills in patient education. To be useful, medication instructions must be written at the reading level of the people who will be following the instructions. It has been estimated that the average reading level of the American public is approximately seventh to eighth grade. However, many adults cannot comprehend material written at these levels. Therefore, pharmacy educational materials should be written at the reading level of the patient population being served. Several readability formulas have been developed. Among the ones recommended for use in drug education materials are the Fry Readability Graph and the Funning Fog Index. 41 references.

81-1653
The Education Function in Hospitals: A Guide for the Organization and Administration of the Hospital's Educational System.
American Hospital Association, Chicago, Ill. American Society for Health Manpower Education and Training.
Chicago, Ill., the Society, 30 p., 1978.

Guidelines for the organization and administration of hospital educational systems are provided to help hospitals develop a unified approach to structuring educational services. The guidelines were prepared in 1976 by a committee composed of members of the American Society for Health Manpower Education and Training. The rising expectations of hospital employees and rising labor costs as well as the increasing need to monitor government activities in the areas of health insurance and reimbursement for patient education have resulted in the need for hospitals to integrate and coordinate their educational services. Such integration requires review of the hospital's organizational structure and definition and development of a quality-control mechanism. Developing a comprehensive network of educational programs, encompassing personnel, patients, volunteers, boards of trustees, and the community, involves defining educational philosophy and hospital policy, preparing the staff, determining organizational procedures, developing educational programming, and providing liaison with outside sources. Finally, the health educator must have knowledge of and skills in management, learning theory and processes, psychology, human relations, personnel administration, and organizational development.

81-1654
Organizing and Implementing an Inpatient Education Program.
Bader, B. S.
Lutherville, Md., Maryland Hospital Education Institute, 24 p., 1977.

Implementing a patient education program involves adopting a hospital policy on patient education, organizing for patient education, locating funds for the program, surveying other patient education programs and the needs of the patient population, determining educational objectives, evaluating products and programs, and training hospital and medical staff. A 1975 survey indicated that 473 hospitals had a committee to set inpatient education policy, and 89 of those had formed a special patient education committee. A single department should be assigned the responsibility for all inpatient education; the survey showed that 1,278 hospitals had such a committee. A formal patient education program generally consumes 0.25 percent of a typical hospital's budget. Careful attention should be paid to the reimbursement policies of Medicare, Medicaid, and third-party insurers. The health education coordinator should survey all department heads and patient education resources in the community and compile a catalog of the latter. Developing objectives involves identifying target groups, optimal times and places of educational interventions, required information, patients' educational abilities, and persons prescribing educational interventions. Both the products and the cost-effectiveness of programming should be evaluated. Finally, all staff should receive training in interpersonal communication, educational principles, and specific educational content. A media evaluation form and lists of sources of media are appended. 9 references.

81-1655
Behavioral Interventions in Patient Education.
Beardsley, R. S.
Hospital Formulary 13(6):472-477, 480, June 1978.

An examination of the theories on patient learning, motivation, and behavior provides insights into the means by which hospital pharmacists can use behavioral interventions to improve patient compliance with prescribed regimens. Numerous patient drug education programs have increased patient knowledge without concomitant improvement in patient medication behavior. Patients may respond to information provided by the pharmacist by integrating the information into their behavior, memorizing the information for later use, disregarding the information as unimportant, or failing to listen to the information provided. To ensure that one of the first two possible

responses is made by the patient, the pharmacist must understand modeling processes involved in social learning, behavioral reinforcement, and other social, cultural, and environmental influences that affect the learning process. Patients are motivated to learn a particular behavior by the value of the goal to which the behavior is expected to lead and the expectation that performing the behavior will lead to that goal. Patients' decisions are also affected by their perception of the pharmacist as an authoritative source of information. Hence, pharmacists should be aware of verbal and nonverbal messages that they send and receive. Private consultations with patients is essential to adequate pharmacist-patient communication. Effective exchanges are more likely when the pharmacist is attentive to feedback from the patient, asks probing questions, demonstrates the relevance of the information, reinforces the teaching experience, provides followup, and elicits the help of other health professionals in reinforcing the teaching experience. 15 references.

81-1656
Patient-Physician Negotiation.
Benarde, M. A. and Mayerson, E. W.
Journal of the American Medical Association 239(14):1413-1415, April 3, 1978.

Negotiation can help the physician and the patient reconcile their goals, encourage patient participation in treatment, and improve the chances that the patient will comply with therapeutic recommendations. It is essential that patients feel independent, worthy, and able to deal with knowledge about pertinent health matters. Physicians should be responsive to nonverbal messages as well as direct questions and take a positive attitude toward the patient's treatment. Instruction and information should be given at a measured rate, in short segments, with numerous pauses and repetition. Using explicit lay terminology and obtaining feedback from the patient are important. Patients' affective and cognitive responses to the therapeutic regimen should be assessed. The goals of both physician and patient should be outlined clearly before any decision, and a give-and-take atmosphere should be established. 11 references.

81-1657
Participation: The Key to Learning for Patients in Antepartal Clinics.
Bonovich, L.
JOGN Nursing 10(2):75-79, March-April 1981.

A program was implemented in a large, inner-city antepartal clinic in which a clinical instructor in maternity nursing conducted discussion groups with patients for 4 months, after which responsibility for patient education was assumed by the nursing staff. Patients were invited individually to participate in discussions focusing on personal care in pregnancy, labor and delivery, and infant care. The 45-minute discussions were held twice a week for the 4 months. A total of 166 patient contacts was made. The group process provided a vehicle for expression of feelings, opportunities for reassurance, and direction for particular action. Evaluation of learning retention and subsequent behavior of the participants was not conducted due to time constraints and recordkeeping difficulties. 16 references.

81-1658
Information--A Prescription for Recovery?
Boore, J.
Nursing Mirror (Sussex) 151(24):32-35, December 11, 1980.

A study of 80 patients admitted to the hospital for cholecystectomy or herniorrhaphy procedures was designed to discover the effects upon patient anxiety levels of providing the patient with information, involving the patient in a self-care role, and discussing the patient's anxieties. The 40 patients in the experimental group received information about pre- and postoperative procedures and experiences; instruction in deep breathing, coughing, exercising the legs, and relaxing the abdominal area; and encouragement to ask questions and discuss feelings and anxieties. The 40 control patients were engaged in unfocused conversations. Assessment of patient fluids indicated that (1) experimental patients had significantly lower postoperative levels of steroid hormones than control patients; (2) experimental patients undergoing herniorrhaphy procedures had the lowest levels of steroid hormones; and (3) experimental patients undergoing cholecystectomy procedures suffered significantly fewer infections than their counterparts in the control group. It appears that the preoperative counseling and education offered in the program helped experimental patients' immune systems to operate at optimal levels. The implications of this conclusion suggest the need to incorporate similar programs into the treatment of cancer patients. 13 references.

81-1659
Patient Education for the Family. Practical Patient Aids for Health Care Professionals.
Brunworth, D. and Rigden, S.
Hagerstown, Md., Harper, 109 p. (loose-leaf), 1979.

Reproducible patient ed[illegible]ation materials are provided for family practice profession[illegible]. Materials provided are related to behavioral science; dermatology; exercise; infections and allergies; medical assessments and interventions; muscular and skeletal trauma; nutrition; obstetrics and gynecology; and pediatrics. The patient education materials may be reproduced by office copiers for distribution by physicians to their patients.

81-1660
Social Support and Patient Adherence: Experimental and Survey Findings.
Caplan, R. D.; Harrison, R. V.; Wellons, R. V.; and French, J. R. P., Jr.
Ann Arbor, Mich., University of Michigan, Institute for Social Research, Survey Research Center (Research Report Series), 272 p., 1980.

A longitudinal study of 483 ambulatory hypertensive patients treated at 5 clinics examined the effect of social support on patient motivation to follow prescribed medical regimens for hypertension. When recruitment letters were sent, the patients were assigned to a control group or one of two experimental groups. One experimental condition involved social support by a nurse in a one-to-one clinical setting; the other involved social support by a significant other (spouse, relative, neighbor, friend). A total of 236 patients from the original 483 patients completed questionnaires at 4 different times in 1 year. In addition to the experimental techniques and questionnaires, program assessment involved records of patients' appointment-keeping behavior; time spent with nurses; return of letters that were sent halfway through the program that inquired about patients' progress; and change in blood pressure levels. Analysis of the 236 patients indicated that (1) adherence to the regimen was the most important predictor of blood pressure level; (2) objective knowledge of the regimen was another predictor of blood pressure level; (3) patients with the least controlled blood pressure received the most medical support; and (4) social support from nurses, physicians, and significant others lowered the number of patients' somatic complaints. Study findings have a bearing on diagnosis of compliance problems, timing of interventions, and development of intervention strategies. A detailed analysis of the study is provided. Numerous references.

81-1661
New Directions in Patient Compliance.
Cohen, S. J., ed.
Lexington, Mass., Lexington Books, 170 p., 1979.

On August 11 and 12, 1978, the Diabetes Research and Training Center at Indiana University sponsored a conference on patient compliance for the staff of the diabetes research and training centers established by the Federal Diabetes Act and other interested professionals. The conference addressed the relationship of attitudes and other psychosocial factors to patient compliance; application of old research to future problems; issues in assessment of patient compliance; factors related to the patient, the provider, and the organization that determine adherence; problems in conducting a study of the effects of teaching in regard to compliance with antacid therapy; the computer's role in detecting and reducing physician errors; research methods that are translatable to the practice setting; and use of methods outside the realm of the traditional hypothesis-testing approaches to identify contextual constraints to human behavior. Numerous references.

81-1662
A Little More Than Medicine.
Coles, R. B. and Whyman, M. R.
Health Education Journal (London) 36(4):114-115, 1977.

The Skin Department of the Northamptonshire Area Health Authority in England has developed a health education program for patients with acne or psoriasis. Group instruction helps patients overcome fear of their particular skin disease and understand the treatment. A teaching machine provides 15-minute slide-tape presentations. This program has proved useful for leading into group discussion and has increased attendance at the department's regular weekly meetings. Family participation is encouraged, and discussions involving patients, family members, and professionals follow the machine sessions. The programs are presented to 500 individuals and to numerous groups each year. 5 references.

81-1663
Application of Behavioural Science Research to the Dental Office Setting.
Coombs, J. A.
International Dental Journal (The Hague) 30(3):240-248, September 1980.

One-to-one intervention between patient and dentist offers opportunities for practitioners to improve their patients' oral health behavior. Dentists and hygenists should remember that (1) factual information alone does not provide a sufficient level of motivation for patients; (2) an appropriate educational diagnosis must be derived from accurate assessment of the patient; and (3) patient participation in treatment should be encouraged. In developing

programs for improvement of oral health behavior, the practitioner should assess each patient's dental education needs, make a health education diagnosis, increase the patient's motivation to adopt the prescribed preventive behavior, and monitor and reinforce the patient's progress. A concerted effort must be made to reduce dental-related anxiety and fear. Successful anxiety-reducing procedures include relaxation techniques, modeling, desensitization, presurgical waiting periods, hypnosis, distraction procedures, and patient-control methods. Evaluation of methods can be achieved through patient self-reporting and -recordkeeping and clinical assessments. Numerous references.

81-1664
Adolescent Parenting Program: Prenatal and Postnatal Care.
Creedon, M. P.
Journal of Current Adolescent Medicine 2(5):11-22, May 1980.

The Adolescent Parenting Program (APP), a collaborative effort of the Dysfunctioning Center, the Department of Obstetrics and Gynecology, and the Department of Pediatrics at the Michael Reese Medical Center of Chicago, addresses the needs of adolescent primiparas and their infants. APP goals include provision of academic assistance; information on pregnancy, labor and delivery procedures, contraception, and relaxation and breathing techniques; self-care education that stresses exercise and physical fitness; parenting skills; and regular screening to assess infant development and reinforce good parenting skills. The program includes counseling and visits to the labor and delivery rooms. Evaluation methods used by the program include assessment of numerous drawings submitted by participating mothers upon admittance, 6 weeks after giving birth, and on their baby's first birthday. In addition, all mother-child pairs are videotaped periodically during 10-minute play periods; these tapes are compared with those of control pairs filmed at a well-baby clinic. Results of a preliminary report encompassing APP efforts with 27 mothers revealed that a flexible, multidisciplinary approach that recognizes developmental crises and provides for nurturance and opportunities for physical and psychosocial well-being can positively affect pregnant teenagers. 4 references.

81-1665
Self-Management Training for Children With Chronic Bronchial Asthma.
Creer, T. L. and Burns, K. L.
Psychotherapy and Psychosomatics 32(1-4):270-278, 1979.

The Division of Behavioral Science at the National Asthma Center in Denver, Colorado, has been applying behavioral techniques to rehabilitate children with chronic bronchial asthma. Results have shown that (1) social-learning techniques can contribute to acquisition of self-monitoring and self-management skills by afflicted children; (2) while some followup data indicate that children continue to perform effective behaviors once they leave the training program, it cannot be concluded that this favorable outcome always follows; thus, programs involving the family should be initiated; and (3) outreach efforts are needed to contact asthmatic children who have not been exposed to educational programs. 17 references.

81-1666
Patient Responsibility.
Dobyns, R. W.
Dental Clinics of North America 22(2):279-284, April 1978.

Dentists frequently assume total responsibility for patients' oral health, a practice which can cause undue occupational pressures. To reduce dentists' stress, patients must be taught to assume individual responsibility for their dental health. Before treatment, the patient is responsible for selecting a general dental practitioner, seeking treatment immediately when a dental problem occurs, and becoming informed about dental health problems by reading articles in newspapers, magazines, and health periodicals. During treatment, the patient should discuss dental problems openly and honestly, accept only a complete and thorough examination, accept a regimen designed by the dentist to prevent further deterioration when unable to pay for thorough dental care, discuss questions about treatment or payment arrangements, keep all scheduled appointments, and accept financial responsibility for treatment. After treatment, the patient should follow the advice of the dentist regarding oral hygiene, diet, preventive maintenance, and recall appointments, and accept the limitations of dentistry. The dental hygienist should be integrally involved in any patient-teaching scheme.

81-1667
Development of a Self-Care Teaching Program for Postoperative Head and Neck Patients.
Dropkin, M. J.
Cancer Nursing 4(2):103-106, April 1981.

The Nurse Practice Committee at the Head and Neck Surgical Unit at Memorial Sloan-Kettering Cancer Center in New York City has undertaken a project to improve self-care skills among patients who have undergone major

surgery. To allay fears concerning difficulties in eating or breathing and social rejection after head or neck surgery, self-care interventions are recommended early in the postoperative period. Dealing with new forms of, or functions for, facial, respiratory, and deglutitive (swallowing) organs requires patient education that redirects self-care energies. To enable staff to predict patient stress levels after release and to provide standardized teaching interventions, teaching cards, which include a written and pictorial description of each self-care procedure, were developed. Although no formal evaluation of the efficacy of the cards has been performed, the overall response to the cards by staff and patients has been positive. Clinical observations have indicated that the cards facilitate patient competence as well as independence in postoperative self-care. 12 references.

81-1668
Observations on Patient and Family Coping With Huntington's Disease.
Falek, A.
Omega; Journal of Death and Dying 10(1):35-42, 1979.

The diagnosis of Huntington's disease influences the quality of life of the patient and the immediate family. Because the disease is an autosomal, dominantly inherited disorder, the diagnosis in a family member has implications for the siblings and children of the affected individual. There is no method of early detection for the disease in the at-risk family members. Definitive problems in counseling families with the disorder are related to the limited precision of the clinical diagnosis and a variety of counseling needs present before onset of the illness. Because patients are subject to consistently deteriorating motor movements and psychological aberrations, they are often labeled as socially dead. Chorea and long periods of muteness are considered by medical personnel, family, and friends as evidence of mental deterioration. Thus, treatment for patients is often conducted without determining their competency to understand or to make decisions about their clinical program. It is dehumanizing when a patient is not allowed to participate in decisions about his or her life, and a loss of dignity results. This may explain the high suicide rate among newly diagnosed patients. Patients and families should be counseled about the disease, its inheritance pattern, and medical treatment based on their psychodynamic response to the sequential aspects of the coping process, which includes shock and denial, anxiety, anger or guilt, depression, and psychological homeostasis. The counselor must identify manifestations of each phase and provide the appropriate reinforcement to the patient and family. 10 references.

81-1669
Assessment of Residents' Attitudes Toward Patient Education.
Falvo, D. and Wright, W. R.
Journal of Medical Education 56(3):200-201, March 1981.

A review of the literature on physicians' attitudes toward patient education, interviews with individual physicians, and a survey of 284 physicians in residence at 20 hospital residency programs across the United States were undertaken to determine residents' perceptions and expectations of patient education. The literature review and interviews were conducted to prepare the questionnaire, which emphasized patient education in outpatient settings. The instrument covered general concepts, responsibility, value, cost effectiveness, and patients' rights with regard to patient education. The instrument included 56 Likert-type scales. Responses indicated that residents thought that (1) patient education consists of providing information on disease, treatment, and prevention; (2) pamphlets and audiovisuals are helpful but not essential to patient education; (3) patient education requires interpersonal contact; (4) patient education is an integral part of total medical care; (5) a specific health education coordinator is unnecessary; and (6) physicians should be responsible for deciding which information is provided to the patient.

81-1670
Asthma Self-Management Project. Third Annual Report.
Feldman, C., et al.
New York, Columbia University, Department of Pediatrics, 34 p., November 1980.
Available from: NTIS; Order No. PB81-127839.

The Asthma Self-Management Project is a health education project designed to teach self-care skills to families with asthmatic children. During its third year, the project completed its educational intervention component, initiated all aspects of the postintervention evaluation, initiated the analysis of the preintervention data based on the 311-subject study population, produced several presentations and publications, and made plans for the its fourth year. Completion of the project's educational intervention involved production and distribution of printed educational materials to all families enrolled in the project's experimental group, distribution of a newsletter and a hotline telephone number, collection of program attendance data, completion of a 12-month educational program for the first group of children enrolled in the program and a 9-month educational program for the second group, and

enrollment of a third group of 67 children in a 6-month educational program. The postintervention evaluation involved developing an evaluation instrument through revision of the preintervention instrument, establishing interview procedures and initiating postintervention interviews, and administering pulmonary function tests and collecting data on school attendance and health care utilization of project subjects. Analysis of preintervention data involved assessment of program attendance, data from preintervention questionnaires, and distribution of responses to study variables. Four papers on the program were presented at professional conferences, and two manuscripts have been accepted for publication. During the fourth year of the project, program staff will continue to collect and analyze data, initiate cost-benefit analysis of programming, and submit proposals for new projects.

81-1671
Teaching Patients: A Practical Handbook for the Health Care Professional.
Freedman, C. R.
San Diego, Calif., Courseware, Inc., 161 p., 1978.

Guidelines for instructing chronic obstructive pulmonary disease patients are provided with the intent that the skills developed by the practitioner using this manual can be applied to any type of patient teaching situation. Chronological steps are provided for developing skills needed to determine patients' learning needs, design the instruction program, present the instruction, and evaluate patient performance.

81-1672
Nursing Protocol to Improve the Effectiveness of the Contraceptive Diaphragm.
Gara, E.
MCN; American Journal of Maternal Child Nursing 6(1):41-45, January-February 1981.

Because the use of diaphragms for contraception is increasing, nurses must begin to use a formal protocol for teaching diaphragm use. The nurse should allow adequate time for a diaphragm-fitting appointment; 45 minutes should be allowed for the first appointment. During this time, the nurse should take the patient's history, instruct the patient in diaphragm use, evaluate the patient's technique for inserting and removing the device, and assess possible problems with its use. Anxieties about sexual spontaneity can be lessened by teaching that the diaphragm can be inserted up to 2 hours before intercourse and by including the woman's sexual partner in the counseling session. The nurse should reinforce the written instructions provided with each diaphragm. Reinforcement counseling should include discussion of spermicide application, proper insertion, the amount of time that must pass before diaphragm removal, care of the diaphragm, consistent use of the device, and optimal sexual positioning to increase contraceptive effectiveness. After contraceptive counseling, a pelvic examination should be performed, and the woman should be fitted using an actual diaphragm rather than a fitting ring. Followup should be provided 1 to 2 weeks after the fitting to check the patient's insertion and removal technique and to provide an opportunity for further questions. 5 references.

81-1673
A Self-Medication Programme for Post-Coronary Patients.
Gillespie, B. J. and Farkas, T.
Canadian Journal of Hospital Pharmacy (Weston) 30(6):188-190, November-December 1977.

At York Central Hospital in Richmond Hill, Ontario, Canada, the interdisciplinary Cardiac Rehabilitation Programme was developed in 1976 for postcoronary patients. Representatives from the community health unit and the departments of nursing, pharmacy, physical therapy and rehabilitation, discharge planning, and educational services were on the planning committee. The patient is taught about heart disease, its effects on lifestyle, the importance of suitable exercise, and the names and purposes of prescribed medications. A model of the heart, a slide-tape program on exercise, and an information booklet supplement program teaching. Participation by the patient's family and friends is encouraged. A self-medication program for patients who have been screened and referred by a physician and a pharmacist involves use of written instructions and medication records. Upon discharge, the patient is interviewed by a pharmacist and the discharge planning coordinator and is subsequently visited by a community health nurse and invited to monthly followup meetings. The 100 patients who have participated in the self-medication program over the past 15 months have exhibited impressive compliance levels.

81-1674
Patient Involvement Utilizing Video Cassettes.
Glen, V. H. F.
Ontario Dentist (Toronto) 57(8):20-21, August 1980.

Dentists should thoroughly understand the various techniques of health education, particularly video technology. The goals of a successful educational program include reducing fear, familiarizing the patient with dental tech-

niques and equipment, eliminating misconceptions, improving the professional image of dentistry, encouraging preventive measures, and ensuring deeper patient involvement. Support from the receptionist, dental assistant, and hygienist is essential to creating rapport between the health team and the patient. Installation of a television for videocassette viewing in the waiting room can reduce the patient's fear while providing education. The familiarity of television makes it an excellent medium for the transfer of oral health information. Video programming is available for staff training, professional and patient education, practice management, and entertainment from the Canadian National Film Board and other associations. Dentists may also produce their own educational films of office procedures or specialized treatments.

81-1675
Gonococcal Infection: The Effect of Educational Counselling on Patient Compliance.
Goodrich, K. K.
British Journal of Venereal Diseases (London) 57(2):137-140, April 1981.

One hundred consecutive patients with gonorrhea attending a venereal disease clinic in London, England, were studied to determine whether improving patients' understanding of the disease, its treatment, and the need for contact tracing increased patients' willingness to report for followup examination. The patients were divided into two groups, one that received individual counseling about the nature of the disease and its treatment and another whose members were questioned individually about their attitudes toward the clinic, expectations about examination and treatment procedures, sources of information about sexually transmitted diseases, and beliefs about the disease. Treatment compliance was measured by counting the number of attendances at followup appointments. Analysis of data, including routine epidemiological and demographic data, from 91 patients indicated that (1) counseled patients had a higher followup rate than noncounseled patients; (2) the major source of information on sexually transmitted diseases was the peer group; (3) the clinic was well accepted by patients; (4) an atmosphere of anonymity (fostered by referring to patients by numbers) and the staff's nonjudgmental attitude were well accepted by patients; and (5) educational counseling was relatively time consuming. A larger study is needed to determine whether increasing compliance through educational counseling is cost effective. 4 references.

81-1676
Medication Discharge Counseling Program Developed by Pharmacists.
Kaufman, R. L.; Cotnoir, G. M.; and Holm, A. L.
Hospitals 52(1):89-92, January 1, 1978.

The department of pharmacy at the Miriam Hospital, a 247-bed teaching hospital in Providence, Rhode Island, developed a patient education program to assist patients in complying with prescribed medication regimens. The pharmacists counsel patients concerning their medication regimens, analyze medication histories, and provide patients with written instructions that reinforce physicians' verbal instructions. If patients enter the program, physicians may sign either consent forms for each patient that they wish to have counseled or blanket consent forms, allowing any of their patients to be counseled. To overcome counseling inexperience, pharmacists meet with the nursing staff for inservice sessions and read articles and listen to audiocassettes on counseling. Information packets provided to patients leaving the hospital contain medication calendars, appropriate drug information cards, medication information sheets, and an evaluation questionnaire. Each discharged patient is assigned a specific pharmacist who can be called or visited for counseling. Data from returned evaluation questionnaires indicate that the program increases compliance levels and that patients would benefit from counseling by community pharmacists.

81-1677
Loss and Recovery: The Role of the Hospital Staff in the Rehabilitation of a Patient Who Has Undergone Mastectomy.
Kilgore, M. E.
QRB. Quality Review Bulletin 4(1):25-26, January 1978.

Women who undergo mastectomy face physical and psychological problems that may affect their recovery and rehabilitation. Hospital staff should be aware of the patient's individual situation to provide necessary supportive care and effective pre- and postoperative instruction. Primary concerns affecting the patient's reaction to the surgical procedure include disfigurement, loss of femininity, and loss of sexual appeal. Experiences with family members who express negative feelings or misapprehensions, magazine and newspaper articles and rumors to which the patient may have been exposed, anxieties about informing children, and exposure to another's experience with mastectomy may influence the patient. Preoperatively, the patient should be informed about the surgical procedure and the need for intravenous feedings, a protective pressure dressing, and a Penrose drain. Postoperative instruc-

tion should include coughing and breathing techniques, arm exercises, and means of preventing infections and edema in the arm or hand. Before discharge, the patient should be instructed on breast self-examination for early detection of recurring cancer.

81-1678
The Value of In-Hospital Patient Groups for Renal Transplant Recipients.
LaMantia, C.
Journal of the American Association of Nephrology Nurses and Technicians 8(1):32-34, February 1981.

The transplant unit of the Montefiore Hospital in New York City has instituted weekly group counseling sessions for persons with renal transplants to allow such persons to express concerns and feelings about their situation. The smallest group so far was made up of two patients; the largest group included six patients. The patients range from 18 to 55 years old and come from a variety of social, economic, and cultural backgrounds. Family members and significant others are invited to join the sessions. A member of the renal unit nursing staff and a social worker are the codirectors of the group. The codirectors focus on medical concerns of the group, important concepts, and group process and dynamics. A liaison psychiatrist is available as a resource person, but does not participate in the 90-minute meetings, which are designed to be informal talk sessions. The focus of group interest has included factors involved in the decision to undergo transplantation for end-stage renal disease, traits of donors, adjustment to transplantation, patient-staff interaction, and patient education. The group provides a constructive setting in which patients can express their feelings, share experiences, give and receive support, and generally develop a sense of togetherness. Staff involved in similar groups should do whatever they can to mitigate problems arising from the small patient census, illness of recipients that prevents their attendance, and language difficulties affecting meetings in which patients have varied backgrounds.

81-1679
Drug Misuse Among the Elderly: An Educational Challenge for Health Professionals.
Levy, M. R. and Glanz, K.
Journal of Drug Education 11(1):61-75, 1981.

A review of the literature indicates that misuse of prescription and nonprescription drugs by the elderly is a growing problem in the United States. Such misuse by the elderly is related to the decline in mental abilities during old age, lack of social supports for the elderly, unanticipated reactions to drugs due to the psychological changes of aging, language barriers impeding communication between elderly patients and physicians, complex medication schedules involving a number of drugs, and dependence on over-the-counter drugs as a substitute for proper medical care. Research indicates that sociodemographic factors are poor and inconsistent predictors of adherence to drug regimens, though older people and low-income people have been repeatedly found to perform poorly on adherence measures. Precursors of good compliance levels have included knowledge of the specific disease, information about the regimen, knowledge of the appropriate way to take medication, and possession of written information on the drug regimen. Major sources of drug information for the elderly include physicians, nurses, pharmacists, and paraprofessionals. Unfortunately, the potential of a combined effort by professionals to improve drug compliance among the elderly has been undermined by the documented failure of these professionals to provide counseling. Hence, patients have relied on their own judgment or that of friends. Encouragement of familial and social support networks and cooperation among health care professionals could go far in decreasing drug misuse by the elderly. 89 references.

81-1680
Foot Care for Your Diabetic Patients.
Luce, B.
Journal of Practical Nursing 31(2):28, 39, February 1981.

Education concerning proper foot care is an essential part of patient education programming for diabetics. Nurses should instruct patients to check feet often for injuries and signs of infection, bathe feet daily in lukewarm water and mild soap, dust feet lightly with dusting powder wherever excess moisture accumulates, file toenails straight across to prevent ingrown toenails, avoid exposing feet to heat or chemicals, refrain from going barefoot, wear leather shoes, wear clean socks, avoid tight socks, elevate the feet wherever possible, change shoes during the day, and see a podiatrist on a regular basis.

81-1681
The Practitioner-Teacher Role: Practice What You Teach.
Machan, L., ed.
Wakefield, Mass., Nursing Resources (Nursing Dimensions Education Series, Vol. I, no. 3), 185 p., 1980.

Guidelines concerning the role of the nurse practitioner as a teacher, the function of interagency collaboration in successful implementation of patient teaching, resolution

of role implementation problems, and educational preparation of the practitioner as teacher are provided for nurse practitioners. Topics include practitioner-teacher models, the nurse educator's dilemma, socialization for survival in the academic world, development of a staff research potential, development of a role-oriented model for graduate education, use of the log as a teaching tool in a role-development course, preparation of the practitioner as a teacher of nursing, and implementation of continuing education plans in patient teaching. Numerous references.

81-1682
Source List for Patient Education Materials.
Martyn, D. E.; Spencer, D. A.; and Duke, P. M.
Wauwatosa, Wis., Health Sciences Communications Association, 47 p., May 1978.

Sources of patient education materials are provided for use by health educators and other health care practitioners. The resources include names and addresses of national and professional health organizations, libraries, Federal agencies, and private producers and distributors of patient education materials. A subject index is appended.

81-1683
Improvement of Patient Care Management in Iowa Hospitals. Final Report to W.K. Kellogg Foundation From Iowa Hospital Education and Research Foundation.
Mary Brigid, Sister, et al.
Des Moines, Iowa, Iowa Hospital Education and Research Foundation, 165 p., September 1979.

The Iowa Hospital Association (IHA) has adopted the "Conceptual Model for Transferability" (which was developed during the State's 3-year Nurse Utilization Research Study and Evaluation project) to use in the implementation of the Improvement of Patient Care Management in Iowa Hospitals project. During the first year of the project, 21 hospitals were selected for participation. Seven hospitals were added during the second year, and five during the final year. The program included components for restructuring the delivery of episodic nursing and for developing health education programs. The health education component involved (1) developing programs in inpatient education, outpatient education, employee education, and community education; and (2) forming health education committees for community and patient education. Evaluation assessed outcomes related to nursing practice, health education, and communication and resulted in recommendations that (1) hospitals be helped in carrying out their wellness center roles, (2) a wellness program be implemented for employees through the joint efforts of the IHA and the Iowa Hospital Education and Research Foundation, and (3) opportunities be provided for nurses to develop management skills.

81-1684
Helping Your Diabetic Patients Help Themselves.
Pelczynski, L. and Reilly, A.
Nursing 11(5):76-81, May 1981.

The patient education program for diabetics at Carney Hospital in Boston, Massachusetts, uses four publications as the core of the training effort. The tools include a handout that outlines the hospital's standards of care for diabetic patients; a one-page questionnaire to assess the patient's understanding of diabetes; a one-page patient-teaching record form; and a patient-teaching packet that includes handouts on hypo- and hyperglycemia, urine testing, and insulin preparation and injection techniques. After assessing patient needs, staff record the needs and expected outcomes on a card file and on a patient-teaching record form and begin to plan teaching sessions. Patient teaching is individualized. 8 references.

81-1685
Why Don't We Teach and Treat Diabetic Patients Better? (Editorial)
Pirart, J.
Diabetes Care 1(2):139-140, March-April 1978.

Uncoordinated diabetes education in Belgium causes patients to follow erratic paths while seeking treatment and an understanding of the disease. Moving from doctor to doctor and hospital to clinic frequently results in several hypoglycemic and acidotic episodes for the patient. To remedy this situation, diabetes specialists must convince physicians that (1) a comprehensive educational approach can be effective; (2) a good physician-patient relationship will increase the effectiveness of the doctor and the confidence of the patient; and (3) education is possible and patients are more educable and motivated than is usually believed.

81-1686
The Teaching Function of the Nursing Practitioner.
Pohl, M. L.
3rd ed. Dubuque, Iowa, Wm. C. Brown (Foundations of Nursing Series), 156 p., 1978.

The role of student and professional nurses as patient educators is described for use in developing preparatory, inservice, and individual learning programs. Basic princi-

ples of learning and teaching are presented and applied to various nursing situations. Topics presented include the nature of the learner and problems that may interfere with learning, content of patient education programs, educational methods and materials, planning a patient education program, and evaluation of patient teaching and learning. Emphasis is placed on client-centered teaching, client-nurse cooperation in the teaching-learning process, and the importance of the nurse's recognition of cultural differences. Numerous references.

81-1687
Dx: Osteoporosis. Rx: Patient Teaching.
Rausch, E. and Haessig, C. J.
Journal of Practical Nursing 31(2):26-27, 39, February 1981.

Since osteoporosis (mineral loss in the bones) is incurable, the nurse as patient educator can play an important role in helping persons afflicted with the disease to slow its progress and in preventing the onset of the disease in women, who are particularly prone to the malady. The disease has been linked with calcium imbalances, particularly if such imbalances occur in combination with dropping estrogen levels during and after menopause. Modulation of protein and phosphorus intake can prevent calcium losses that may lead to osteoporosis. Provision of mineral supplements to replace lost calcium and fluoride may offer another means of preventing the disease. To help patients prevent or alleviate the disease, nurses should encourage outdoor activity, consumption of foods with high calcium contents and vitamin D, and substitution of fresh foods for processed foods to lower the amount of phosphorus in the body. The 1980 recommended dietary allowance for calcium is 800 milligrams. Sources of calcium include dairy products, dark green leafy vegetables, baked beans, and broccoli. Patients should be encouraged to seek regular exposure to the sun. 7 references.

81-1688
A Combined Approach to a Medical Problem: The Canadian Back Education Unit.
Robinson, G. E.
Canadian Journal of Psychiatry--Revue Canadienne de Psychiatrie (Ottawa) 25(2):138-142, March 1980.

The Canadian Back Education Unit is a team approach to a medical problem. The team consists of orthopedic surgeons, psychiatrists, psychologists, and physiotherapists who give a course of four lectures to patients with low-back pain. The patients are taught the anatomy and physiology of their pain, proper postures and exercises, the way in which emotions can complicate their physical problem, and relaxation techniques. The course format allows patients to share feelings and experiences in a supportive atmosphere. Of the 934 people who have completed the 6-month review course, 77 percent rated themselves as improved and 96 percent thought that the course had been helpful. Also, a 62 percent decrease was noted in the number of patients seeing doctors about back pain. It appears that the team approach to educating patients about low-back pain is effective and cost efficient. 9 references.

81-1689
Problems in Conducting a Study of the Effects on Patient Compliance of Teaching the Rationale for Antacid Therapy.
Roth, H. P.
In: New Directions in Patient Compliance. Cohen, S. J., ed. Lexington, Mass., Lexington Books, p. 111-125, 1979.

After a retrospective study was conducted of patients under antacid therapy (a study which suggested that education could increase patients' intake of antacid medication), another study was undertaken to determine the actual effectiveness of patient teaching. Preliminary studies indicated that self-reports by patients and physicians' estimates of patient compliance were grossly inadequate for estimating compliance, and that combinations of assessments, including blood tests, pill and bottle counts, and patient interviews, appear to provide better estimates. The sample population of the main study was divided into a control group that received no intervention, a group that received teaching that did not touch on concepts key to the therapy, and a group that was instructed in key concepts. During the prolonged pilot period, patient misconceptions were identified and different teaching approaches were assessed. Instructors used the Socratic method and taught patients individually. Program assessment involved evaluation of the language in which patients answered questions, patients' knowledge of background material, and patients' ability to apply knowledge. Variations in patients' intelligence levels created some assessment problems. The relationship between the teaching and patient compliance is being evaluated.

81-1690
Austin Diagnostic Clinic, Continuous Ambulatory Peritoneal Dialysis Training Program.
Sorrels, P. A. J.; Kruger, V. J.; Moncrief, J. W.; and Popovich, R. P.
Excerpta Medica. International Congress Series No. 520:-167-170, 1980.

The Austin Diagnostic Clinic in Texas has developed a continuous ambulatory peritoneal dialysis (CAPD) outpatient training program. The ambulatory care program offers patients an opportunity to establish a positive CAPD experience while avoiding the clinical situation and to accept dialysis as routine for family life. After peritoneal catheter implantation and the required rest period are completed, training begins, usually on a Monday so that patients may perform exchanges by themselves by the end of the first 6-day training week. The first phases of training are usually no longer than 2 hours, and five to seven exchanges in a training day are not uncommon. During this time, patients are instructed in normal kidney function, dietary requirements, other forms of dialysis, and complications of end-stage renal disease. Using one-to-one instruction techniques, nurses emphasize personal hygiene and encourage patients to ask questions about the self-care treatment. A teaching objective checklist is completed at the end of each day to allow nurses to alternate patients without diminishing the learning experience. When patients are able to perform exchanges by themselves, usually after a week, a regimen of four exchanges per day is established and followed throughout the rest of the training. Patients are given a series of knowledge assessment examinations at the end of the training period. Monthly observations of patients' dialysis techniques and weekly telephone contacts ensure proper followup. The familiarity of the outpatient setting, as opposed to the clinical setting, is the program's chief advantage, though the clinic also benefits from being unaffiliated with any hospital. Outpatient training, however, can be expensive for out-of-town patients and burdensome for staff. 7 references.

81-1691
The Child With a Tracheostomy: A Holistic Approach to Home Care.
Talabere, L. R.
Topics in Clinical Nursing 2(3):27-44, October 1980.

A holistic framework for home care of the child with a tracheostomy can help health care professionals realize contributions that the child and the family can make to their own health care and help affected children and their parents comply with prescribed therapeutic regimens. Using the concepts of family, wellness, and self-responsibility, the holistic framework recommends that (1) parents be a part of their child's care from the beginning; (2) preparation for home care include a careful assessment of child and family perceptions, needs, readiness, and resources; (3) siblings of the patient be participants in the home care; (4) home care foster a balance among wellness, prevention, and illness management behavior for all family members; (5) an attitude of self-responsibility be encouraged in the child and family; and (6) the home care plan encourage the ability to respond to the self as a means of increasing child and family control of the situation and reducing stress. Pre-intervention assessment should consider typical responses involved in families' reactions to illness, the child's response pattern, the impact of illness on the family's daily life, resources available to the family, and the abilities of the staff. The teaching plan should cover the nature of the diagnosis, activities of daily living, oral hygiene, bathing, care of the stoma, clothing and bedding, safety, communication, appearance, respiration, suctioning, emergency measures, lifestyle changes, and community and followup care. 34 references.

81-1692
Dispensing Facts, Dispelling Fears.
Walton, A. V.
Journal of Practical Nursing 30(5):25-26, 39, May 1980.

The nurse practitioner must consider the social, psychological, and physical needs of epileptics. Nurses questioned at numerous workshops held over the past 3 years at the Comprehensive Epilepsy Program in Minneapolis, Minnesota, indicated that fear of the disease is due to its chronic nature, episodic and uncertain manifestations, and effects on the brain. Nurses are in a unique position to help epileptics cope with these fears, since nurses may not seem as threatening as doctors and may have more time for patients. When dealing with the newly diagnosed epileptic, the nurse should be aware of the patient's current needs, medication requirements, and emotional responses to the disease.

81-1693
The Role of the Patient Education Coordinator.
Zonca, B. M.
Supervisor Nurse 11(12):21-24, 26-27, December 1980.

Responsibilities of patient education coordinators include implementation of needs analysis, development of goals and behavioral objectives, implementation of task analysis, specification of sequential educational activities, formulation and implementation of evaluation procedures, and modification of the educational intervention system in response to feedback. Needs analyses can be conducted by interviewing staff and patients, conducting questionnaire surveys, and observing interactions among staff members and between staff and patients. Goals and objectives provide boundaries for program development, philosophical bases for a program, and organization for curriculum components. Each objective should be

analyzed to delineate its component tasks, which include skills, knowledge, and prerequisites for success. Tasks should then be restated as performance objectives. Structural analysis of behavioral objectives provides the health educator with the sequence in which competencies should be learned. Before implementing the instructional program, the educator must determine the optimal media and activities and design evaluation procedures. Evaluation designs include pre- and postprogram designs, formative designs, and summative designs. The educational intervention should be modified according to feedback from the evaluation data. 14 references.

PROFESSIONAL EDUCATION AND TRAINING

81-1694
Counseling and Human Sexuality: A Training Model.
Fyfe, B.
Personnel and Guidance Journal 59(3):147-150, November 1980.

A counseling and human sexuality course model has been developed that provides counselors with information on human sexuality and assists them in exploring the emotional aspects of sexuality. Topics covered in the 35 to 40 hours of classroom time include (1) sexual awareness; (2) sexual value systems; (3) sexuality in the counseling process; (4) identification and treatment of sexual dysfunctions; and (5) enhancement of sexual responsiveness. Specific instructional methods used to facilitate affective learning include values clarification and use of body language, fantasy, dyad sharing, psychodrama, and small group interactions. Educational methods include lectures, films, large group discussions on sexual research and therapy, and discussions of sexual variations. The course has been offered in a 5-day intensive workshop and a weekly meeting format to various postgraduate students and mental health practitioners attending extension courses. Although no statistical data have been collected, self-report data indicate a high rate of acceptance by participants. An evaluation form is being developed. 35 references.

81-1695
Teaching and Research on Women's Health Issues in Schools of Public Health.
Oakley, D.
American Journal of Public Health 70(7):732-735, July 1980.

Questionnaires sent to 22 schools of public health at the end of 1978 obtained data on the proportion of females in the student bodies and faculties and on the quality and type of instruction and research on women's issues conducted at the schools. A 100 percent return rate was obtained, although certain items were unanswered on some questionnaires. Data on historical trends in representation of women among students and faculty were obtained from the Association of Schools of Public Health (ASPH). Since the 1974-75 academic year, when ASPH began collecting data, the proportion of women students enrolled in schools of public health increased from 46.2 percent to 51.2 percent. The increase was largely related to increased enrollment of women in schools of health education and behavioral and social sciences, traditionally women-dominated fields. From the 1976-77 through the 1978-79 academic years, the proportion of female instructors increased from 20.7 percent to 21.5 percent. Only 3 of the 22 schools did not offer instruction and research opportunities on women's health issues. Women's health problems, particularly those related to maternal and child care, were leading subjects of research and course instruction. A school's interest in women's issues was positively and significantly related to the number of women on its faculty. 4 references.

81-1696
The Health Education Coordinator.
Price, J. H.
Health Education 8(1):40, January-February 1977.

The criteria applied to health consultants should ensure the selection of people who have the respect and confidence of both classroom teachers and State educational leaders. Health consultants should have the highest health education certification requirements possible; have taught health in public schools for at least 3 to 5 years; and demonstrate continuing professional growth through membership in national organizations associated with health education, attendance at professional conferences, and participation in State and national committees. In addition, a consultant should demonstrate leadership qualities, concern for improving the instruction and status of health education, and personal qualities that promote cooperation. Obstacles facing health coordinators include untrained or unqualified teachers, inertia on the part of administrators, failure of key persons to appreciate the value of health education, insufficient time allotted to health education, and lack of budget support.

81-1697
Dental Health Education.
Stoll, F. A.
5th ed, Philadelphia, Pa., Lea and Febiger, 235 p., 1977.

Material pertinent to dental health curricula for primary and secondary school students is provided for use in workshops and inservice lectures and demonstrations for health teachers. Topics include the nature of dental health education, significance of dental health to total health, application of psychological concepts to dental health instruction, opportunities for individual instruction during dental health treatment, dental disease as a public program, community dental health programs, a successful statewide dental health program, dental treatment for all children, preventive measures for dental health, diet as a preventive measure for dental health, plaque control, home dental hygiene regimens, educational concepts applied to dental health education, formulation of dental health program plans in schools, improved methods of teaching dental health, units of teaching in dental health, educational media and learning opportunities, and group activities and interactions in dental health. Appendices include a list of professional journals and other sources of dental health material and information and a discussion of the growth and function of the mouth and teeth. Numerous references.

81-1698
Report of a Project to Develop a Model Health Education Program for Handicapped Children and Their Families.
Texas Univ. Health Science Center, Houston. Division of Continuing Education.
Houston, Tex., the Center (Continuing Education Processes and Programs for Health Professionals), 173 p., February 1977.

The Bureau of Health Education contracted with the University of Texas to develop a model program for enhancing the capabilities of community health professionals to conduct health education for handicapped children and their families. The project developed, implemented, and evaluated health education programs for use by home health educators; sponsored a 2-day conference for health professionals associated with Mexican American health programs; and developed an educational plan for community health professionals. In the model health education program, a curriculum was developed based on project objectives, education and group therapy, and the needs of learners; training for teachers covered client involvement, assessment of client needs, utilization of educational resources, and interaction processes for health professionals. An evaluation, which assessed project administration, participant reaction, the educational process, and resources and materials used, produced the following recommendations: (1) the training process should be initiated through group activities in conjunction with individual self-evaluation exercises; (2) individualized training-needs profiles should be used to establish trainee needs; and (3) the program model should be revised and field tested. A list of project participants, a narrative description of activities, and copies of forms used during the project are appended.

REGULATION, LEGISLATION, AND ADMINISTRATION

81-1699
Disease Prevention and Health Promotion Act of 1978: Hearings Before the Subcommittee on Health and Scientific Research of the Committee on Human Resources, U.S. Senate, 95th Congress, 2nd Session on S. 2115.
Washington, D.C., Committee on Human Resources, U.S. Senate. 941 p., May 25, June 7 and 9, 1978.
Available from: Senate Document Room, U.S. Capitol Bldg., Rm. S-325, Washington, D.C. 20510.

During the 2nd session of the 95th Congress, the Subcommittee on Health and Scientific Research of the Committee on Human Resources of the U.S. Senate held hearings on the proposed establishment of a comprehensive disease prevention and health promotion program for the nation. The subcommittee heard testimony by 15 expert witnesses and representatives of 49 organizations and associations and reviewed numerous articles and other publications on prevention and promotion.

81-1700
An Experiment in Health Care and Protection and Its Implications for Dentistry.
Fuller, J. F.
Annals of the Royal Australian College of Dental Surgeons (Sydney) 6:75-84, November 1979.

An overview of the national character, health care delivery system, and government policies in New Zealand provides a framework to develop preventive dental care. Congruent with the nation's status as a welfare state, its health care structure is dominated by the hospital system. Although this situation has allowed only 39 percent of the

country's physicians to enter general practice, 85 percent of its dentists are in general practice. The other main element in the health system is the department of health, which administers all public legislation relating to the promotion and conservation of health. In addition, there are influential voluntary agencies, and voluntary health insurance shows signs of rapid growth. After the demise of the Third Labor Government's proposal for a national health service in 1974, and the defeat of the party in 1975, a 19-member Special Advisory Committee on Health Services Organization (SACHSO) was established to coordinate public, private, and voluntary efforts. SACHSO proposed that any health organizational structure be tested, developed, and modified in a rural and an urban setting before implementation on a national level. In addition, SACHSO has produced a 14-point framework for achieving the aims of health promotion. Experiments using the decentralized system in a rural and urban setting, recent national epidemiological data, and a report from a workshop of dental health service providers present evidence for the potential development of an effective oral health care system. 14 references.

81-1701
Basic Social Values, Structural Elements in Oral Health Systems and Oral Health Status.
Jenny, J.
International Dental Journal (The Hague) 30(3):276-285, September 1980.

A society's system of oral health care delivery results from an interpretation of social values. The libertarian interpretation emphasizes personal responsibility, expresses social concerns through charitable actions, rejects governmental interference in the private sector, and encourages the link between rewards and efforts. The egalitarian approach accepts the need for social responsibility in providing the services required for a population's well-being, expresses social concern through social engineering, views governmental planning as an expression of public will, and promotes equal opportunity to allow maximum development of the capacities of each person. The libertarian viewpoint promotes an open system based on demand for care provided by the private sector, while the egalitarian viewpoint produces a highly structured system in which care is directed toward needs of the entire population and is provided systematically by the public health service. Research indicates that a highly structured system that facilitates utilization reduces the level of unmet dental needs. The libertarian approach results in a situation in which change in the oral health behavior of the population is sought through attempting to educate the public to make preventive dental visits and practice personal oral hygiene procedures. The libertarian emphasis is on effecting behavior change in the individual rather than on restructuring the system. However, such educational efforts have not been successful on any large scale. A significant alteration of oral health behavior is more likely under a highly structured system that alters the environment to such an extent that individual compliance can be achieved without intensive educational efforts. 18 references.

RESEARCH AND EVALUATION

81-1702
Self-Monitoring and Reactivity in the Modification of Cigarette Smoking.
Abrams, D. B. and Wilson, G. T.
Journal of Consulting and Clinical Psychology 47(2):243-251, April 1979.

A study of chronic smokers sought to determine the value of self-monitoring and whether self-monitoring the nicotine content of cigarettes would be more effective in reducing smoking rates than simply self-monitoring the number of cigarettes smoked. Forty subjects were assigned to one of four conditions from stratified blocks based on initial smoking rates: (a) self-monitoring milligrams of nicotine consumed plus receiving information on the health hazards of smoking; (b) self-monitoring nicotine without receiving health hazard information; (c) self-monitoring cigarettes smoked plus receiving health information; and (d) self-monitoring cigarettes smoked without receiving health information. Subjects self-monitored their behavior during an initial 4-week phase, in which no demands for abstinence were placed on them, and during a 4-week multifaceted behavioral self-control treatment program with a goal of total abstinence. The two nicotine self-monitoring groups showed the greatest change in smoking behavior. However, only the combination of nicotine self-monitoring and health information was significantly more effective in reducing smoking rates than the cigarette self-monitoring conditions. The findings suggest that the efficacy of giving clients advice and information on the health hazards of smoking might be improved by the simple and inexpensive procedure of instructing clients to self-monitor nicotine content. Further research is needed to determine whether the reactive effects of self-monitoring are maintained over time and to explore implications for other types of behavioral self-control. 27 references.

81-1703
Social-Psychological Factors in Motorcycle Safety Helmet Use: Implications for Public Policy.
Allegrante, J. P.; Mortimer, R. G.; and O'Rourke, T. W.
Journal of Safety Research 12(3):115-126, Fall 1980.

A systematically selected sample of 235 motorcycle operators in a State without a helmet-use law was studied to investigate social-psychological factors influencing safety helmet use by cyclists. The subjects were interviewed at 12 motorcycle dealerships in Illinois. Data collected were subjected to multiple regression analysis to test Fishbein's linear model of behavioral intention in predicting intentions to use a helmet from attitudinal and social-normative factors. Results indicated that 53 percent of the variance in behavioral intentions to use a helmet could be explained from attitudinal and social-normative factors; the average correlation for the intention-behavior relationship was 0.86. The principal finding was that the decision to use a safety helmet was based on attitudinal rather than social-normative control. Analysis of the informational system underlying attitude showed that intenders differed from nonintenders on belief factors of the safety and comfort-convenience consequences of helmet use. Findings suggest the need for an educational approach to the problem of nonuse, since individual States appear to be moving away from legislating use. Numerous references.

81-1704
Effect of Health Maintenance Programs on Los Angeles City Firefighters.
Barnard, R. J. and Anthony, D. F.
Journal of Occupational Medicine 22(10):667-669, October 1980.

In 1971, the Los Angeles City Fire Department developed a mandatory physical fitness program that involved a progressive exercise program designed for implementation over three 6-month periods. Each of the nearly 3,000 participants exercised for 45 minutes daily. The program was supported by a manual and a 30-minute film. In 1972, a special cholesterol and weight control component was added to the program. To evaluate the program, a random sample of 300 periodic medical examinations was studied to determine changes in cholesterol, blood pressure, and body weight. Firefighters 39 years old or younger were examined every 2 years; those 40 years old or over were examined annually. Kasch fitness scores were obtained from the entire department in 1971, 1973, 1975, and 1978. To control for changes that might have been caused by laboratory procedures or medical personnel, a sample of 258 Los Angeles police officers' medical records was also evaluated. Results of the fitness scores and other physiological measurements indicated that (1) 39 percent of the firefighters were in poor physical condition at the outset of the program; (2) only 9 percent of the firefighters were in poor condition by 1978; (3) the number of onduty injuries decreased during the last 5 years of the program; (4) serum cholesterol and diastolic blood pressure levels among the firefighters decreased significantly, but there was no significant decrease in systolic blood pressure; and (5) no significant weight reduction occurred in the sample, but those who participated in the weight control and nutrition clinic generally lost weight. 19 references.

81-1705
Sex Education: To Be or Not to Be.
Bhalerao, V. R.; Daniel, E.; Sundar, S.; and Joseph, A.
Journal of Postgraduate Medicine 26(4):253-256, October 1980.

A survey was conducted among 1,070 second-year students attending 13 colleges affiliated with the University of Bombay, India, to assess their knowledge about and attitudes toward sex. The colleges chosen were representative of those in urban and suburban Bombay. The questionnaire included a multiple-choice section designed to assess sexual knowledge and a four-item attitude scale designed to assess degrees of liberalism or conservatism. Data from the 1,070 students who responded to the knowledge section and the 1,018 students who responded to both sections indicated that (1) sexual knowledge was not significantly correlated with attitude toward religion, religious affiliation, caste affiliation, or socioeconomic background; (2) almost 70 percent of the students lacked sexual knowledge; (3) influence of Western culture, lack of parental guidance, the women's liberation movement, and the trend toward sexual emancipation were the main reasons given for promiscuity; (4) over 55 percent considered themselves conservative concerning sexual matters; (5) women were less likely than men to be sexually liberal; (6) over 95 percent thought that sex education should be included in college curricula; and (7) students rarely discussed sex with their parents.

81-1706
What Are the Needs of Nutrition Educators?
Celender, I. M.; Sloan, A. E.; and Tanis, B. H.
Journal of Nutrition Education 10(2):82, April-June 1978.

Five group interviews were conducted by a clinical psychologist with 38 selected educators at the 1976 annual meeting of the Society for Nutrition Education in order to identify their concerns and elicit specific suggestions for change. Major needs of educators include (1) motivating

diverse groups to use nutritional information; (2) raising both the level of awareness and the level of respect for nutrition education; (3) coping with food faddism; (4) overcoming the lack of information and experimental evidence on unresolved nutrition issues; (5) identifying educational tools which are adaptable to various groups; (6) securing the cooperation of food companies in sharing nutritional information; (7) locating administrative and financial support for educational programs and for continuing professional education; and (8) securing background knowledge about target groups. Basic to all needs felt by the majority of the respondents was skill to motivate their audiences to act on sound nutritional information.

81-1707
Mothers' Decisions About Infant Nutrition.
Crummette, B. D. and Munton, M. T.
Pediatric Nursing 6(6):16-19, November-December 1980.

A nurse interviewed 50 mothers during their visits to a well-baby clinic or pediatrician's office to determine the mothers' infant nutrition practices. The children ranged from 6 to 36 months old. Data from the open-ended interviews indicated that (1) cereals were fed to infants at 1 to 4 weeks, followed by fruits at 8 weeks, vegetables, meats, and eggs between the second and sixth month, and table foods and finger foods around the fifth and sixth months; (2) significant others, such as mothers, husbands, close friends, and physicians, have a major influence over mothers' decisions; (3) mothers who had private pediatricians were given different information than mothers who used the clinic (clinic mothers were told to begin feeding solid foods when their infants were between 2 and 5 months old, and mothers with their own pediatrician were told not to add solid foods until their infants were over 6 months old); and (4) established nutritional practices among mothers are difficult to alter. A systematic approach to nutritional counseling for mothers should assist mothers in establishing sound nutritional practices by providing dietary instruction for care of the newborn, the 3-month-old infant, the 6- to 8-month-old infant, and the 1-year-old infant. Frequent telephone contacts with the mother during the infant's first months of life will help the mother initiate good nutrition habits early. 10 references.

81-1708
Youth Culture in the UK: Independence and Round Drinking. Implications for Health Education.
Dorn, N.
International Journal of Health Education (Geneva) 24(2):77-82, 1981.

Attributing drinking behavior among youth in Great Britain to peer pressure and to the influence of advertising may lead to the development of ineffective health education interventions. The materialist framework that has emerged during the 1960's and 1970's superceded existing social science models that gave rise to the peer pressure or advertising view of drinking behavior. In contrast to social science approaches, which analyze ideas or individuals, the materialist perspective considers the social group as the primary analytic unit. The materialist framework views adolescence as a period of transition from youth into one social group or another, rather than as a period of individual development. The transition to independence in the labor market is the central objective fact facing most teenagers, and teenage culture may be seen as a collective strategy for managing this transition. In inner cities in southern England, adolescence is a time for preparing for entrance into the service sector, where sociability and equality between the sexes are essential economic features. Hence, the youth culture stresses these features in its behavioral norms, including norms associated with drinking. The teenagers do not view themselves as dependent on their peers, as current peer pressure models suggest, and such models cannot provide bases for adequate preventive interventions. Different socioeconomic situations will lead to different drinking patterns requiring different intervention strategies. Social models that rely on ideas, individual development, and persuasion, rather than on socioeconomic realities, are likely to be inapplicable. 7 references.

81-1709
Validation of a Poison Prevention Program.
Gill, N. C. and Braden, B. T.
Normal, Ill., Brokaw Hospital, 28 p., 1978.
Available from: ERIC; Order No. ED-172 960.

The Siop Poison Prevention Program, developed by the Brokaw Hospital Poison Control Center in Normal, Illinois, was tested on 156 3- and 4-year-old children enrolled in 8 day-care centers and nursery schools. The program has an educational component and uses warning labels to improve verbal and visual discrimination of poisonous and nonpoisonous products. The sample population was randomly assigned to an educational program using Siop warning labels, an educational program without the labels, a program in which Siop labels were used without the educational component, and a control group. Before and after the interventions, the subjects were administered an 84-item questionnaire that measured their ability to discriminate poisonous from nonpoisonous items and let them express their concepts of poison. Two-way analyses of variance and cross-group descriptive

comparisons of questionnaire data indicated that a combination of the educational program with the use of Siop warning labels proved to be the most effective approach in improving both verbal and visual discrimination of poisonous and nonpoisonous substances. The educational program tended to facilitate intellectual awareness, while the Siop warning labels tended to facilitate visual discrimination. 8 references.

81-1710
Drug Use by Urban and Rural Adolescents.
Gleaton, T. J., Jr. and Smith, S. P.
Journal of Drug Education 11(1):1-8, 1981.

A 90-item, multiple-choice questionnaire designed to elicit data on drug use behavior was administered to 1,959 students in rural and urban communities in Georgia in June 1978. The socioeconomic characteristics of the 1,897 respondents corresponded to the general population of the State identified by the 1970 U.S. census. The questionnaire included 73 items related to experimental and current drug use, reasons for use, and starting age for seven major drugs; the remaining questions explored parental relationships, attitudes toward drug laws, drug knowledge, and school activities. The study population included 754 students enrolled in grades 8-12 in a rural school, and 1,205 students enrolled in grades 9-12 in an urban school. A counselor explained the rationale for the survey before its administration in each school, and respondents were anonymous. Survey results indicated that experimental use of beer, wine, and other alcoholic beverages was high in both schools, and approximately 33 percent of the students reported that they had used marijuana. In both schools, males used more drugs than females on a weekly and daily basis for all types of drugs. The level of drug use in urban and suburban communities was similar, and usage was closely related to the national reported usage level for comparable teenagers. 7 references.

81-1711
Effects of Exercise Training on Coronary Risk Factors in Hemodialysis Patients.
Goldberg, A. P.; Hagberg, J. M.; Delmez, J. A.; Florman, R. W.; and Harter, H. R.
Proceedings of the Clinical Dialysis and Transplant Forum 9:39-43, 1979.

Because atherosclerosis is accelerated in hemodialysis patients, the reduction of risk factors for coronary heart disease with such patients can be of major clinical benefit. Seven patients with end-stage renal failure requiring hemodialysis for 4 to 5 hours three times each week were studied to determine the therapeutic effectiveness of exercise in relation to coronary risk factors. Before participating in the exercise training program, all patients were examined by a cardiologist. Diets were kept constant during training to prevent weight loss; dietary counseling was done monthly, with dietary recalls performed every 3 months to ensure consistency. Periodic medical assessment of the subjects included measurement of body weight, hematocrit, blood pressure, plasma lipids, and high density lipoprotein (HDL) cholesterol. The graded exercise treadmill test and maximal oxygen consumption test were repeated every 12 weeks, and the glucose tolerance test was taken every 16 weeks. The graduated program proceeded from using a stationary bicycle ergometer, which measured the force of muscular contraction, to walking and jogging. Test results indicated that the exercise program was able to partially correct abnormalities in lipid and carbohydrate metabolism (plasma triglyceride concentration was reduced and HDL cholesterol concentration was increased), reduce blood pressure, and improve physical work capacity in some patients. Exercise-induced changes in lipid and carbohydrate metabolism occurred independently of changes in body weight and diet composition, suggesting a direct effect of exercise on the regulation of these metabolic functions in dialysis patients. Four of the participants were able to reduce their required doses of antihypertensive medications. It appears that exercise training may have a beneficial effect on hypertension and abnormalities in lipid and carbohydrate metabolism in hemodialysis patients, reducing the risk of coronary heart disease. 30 references.

81-1712
Research Methods Translatable to the Practice Setting: From Rigor to Reality and Back.
Green, L. W.
In: New Directions in Patient Compliance. Cohen, S. J., ed. Lexington, Mass., Lexington Books, p. 141-151, 1979.

Meeting the problems of evaluating health education efforts under adverse circumstances requires deliberate analysis of evaluation options that consider the trade-offs between validity and feasibility in field situations. The first choice must be between maximizing internal validity or external validity, depending upon the purpose of the evaluation. Then a hierarchy of optional designs can be used to select the design that will optimize internal and external validity. Six strategies can be used to move health education evaluation toward the ideal of experimental control while taking advantage of research methods that compensate for the compromises that must be made for practical, ethical, or developmental reasons; these strategies include using hierarchies of optional designs in decid-

ing the optimal design, promoting discussion and understanding of alternative designs among those who control access to the health service system, adapting and utilizing unobtrusive measures to obtain data, using creatively developed nonequivalent comparison groups when randomization is not possible, and using multivariate analysis techniques. Those interested in conducting compliance intervention studies will need to consider alternative research methods in order to select the most appropriate one for their particular setting. 23 references.

81-1713
Suggested Designs for Evaluation of Patient Education Programs.
Green, L. W. and Figa-Talamanca, I.
Nursing Digest 6(1):77-87, Spring 1978.

The demand for more rational, cost-effective, and relevant patient education programs has given rise to publications on critical assessment of the effectiveness of patient education programs. During the 1960's, many of the evaluation designs used by patient education program studies involved an unsatisfactory single-group, pre- and posttest design. As opposed to studies using two groups and only posttests, pre- and posttest studies using a single group have problems resulting from instrumentation, statistical regression, extraneous historical events, maturation of the subjects, and the effect of the pretest. Many other studies used a design involving a control group and an experimental group which are evaluated at several points to control these problems. However, this design is flawed because the experimental and control groups may not be identical on all variables not being tested at the outset of the study. Further examination of the literature on evaluation indicates that the most important problems in health education evaluation are related to the relationship between evaluation research and planning of educational programming, establishment of goals and formulation of success criteria, and the methodology of evaluation research. Evaluation research designs that have particular pertinence for future institutional patient educational programs include the true experimental design with posttests only; staggered experimental treatments; one-group, pre- and posttest design; two- or multiple-group pre- and posttest designs; and longitudinal trend analysis on one or more groups. 32 references.

81-1714
Rethinking Evaluation Design for Nutrition Education Programs.
Hanson, R. A. and Schutz, R. E.
Journal of Nutrition Education 13(3)86-89, September 1981.

Researchers at the Southwest Regional Laboratory of Educational Research and Development in Los Alamitos, California, have developed an approach for evaluating nutrition instruction programs that is designed to strengthen the operational integrity of programming and determine cost effectiveness. Since program resource integrity is the key determinant of program replicability, evaluability analysis (the initial phase in evaluating a program as a plan or operation) must be undertaken to determine a general definition of program intentions and resources. Program intentions include any specific mandates that govern the program as well as some additional directives specific to the local context in which the program will be implemented. Analysis of program resources entails assembly and review of all available instructional resources and organization of resources in association with intentions. Evaluability analysis generates preliminary estimates of three program variables, namely, resource utilization, expenditures, and effects. Such analysis is to be followed by instructional analysis, analysis of supporting functions, and construction of the evaluation instrument. The next step is to produce estimates of required expenditures for each program resource. Instruments for measurement of program implementation in terms of resource utilization and expenditures may be checklists and logs. Data collected by evaluation instruments can be used to illuminate matters of program operational quality, program comparisons, and program planning.

81-1715
Nurses and Behavior Modification: Resistance, Ignorance or Both.
Hauser, M. J.
Joural of Psychiatric Nursing and Mental Health Services 16(8):17-19, August 1978.

The work role of a staff nurse in psychiatry includes providing a therapeutic environment and teaching. This role is centered around problematic behavior. Social learning theory, principles, and strategies have been very helpful in dealing with problematic behavior. Nurses, however, have not learned or utilized this valuable tool for helping patients substitute adaptive behavior for maladaptive behavior. This situation could be due to resistance or ignorance. Nurses should identify the barriers to adoption of social learning techniques in the care and education of patients so that strategies can be developed to circumvent those obstacles. Nurses could then learn to use behavior modification in their work with patients. 6 references.

81-1716
Evaluating a Learning Device for Juvenile Diabetic Children.
Heston, J. V. and Lazar, S. J.
Diabetes Care 3(6):668-671, November-December 1980.

A study involving 37 insulin-dependent diabetic children, 7 to 12 years old, was conducted to determine the efficacy of a learning package named "OK Insulin" in increasing the children's knowledge of their disease. Most (86 percent) of the children were recruited from the Pediatric-Endocrinology Outpatient Clinic at the University of Michigan Hospital; the remainder were from Mott's Children's Hospital Inpatient Service or local elementary schools. The study sample, which included six control subjects, represented urban and rural communities throughout Michigan's lower peninsula. The OK Insulin instructional package, consisting of a game and booklet, combined cognitive and affective elements to provide diabetic information and to reinforce and evaluate this knowledge in the experimental subjects. All subjects were pretested for diabetes knowledge, after which experimental-group subjects read the booklet and played the assessment game three times. Five children in the experimental group were unable to complete the series, but did complete posttests. The 26 children remaining in the program demonstrated significant gains in knowledge and retained the elevated knowledge levels for a significant period of time. In addition to increasing their general knowledge, the children learned how to identify and respond to hyperglycemia and other problems of juvenile diabetes. The five subjects who could not complete the program showed initial increases in knowledge, but minimal retention. The control subjects demonstrated no increase in knowledge. The instructional intervention was effective because of its entertaining qualities and its age-specific nature. 12 references.

81-1717
Cigarette Smoking and Tobacco Usage Behavior in Children and Adolescents: Bogalusa Heart Study.
Hunter, S. M.; Webber, L. S.; and Berenson, G. S.
Preventive Medicine 9(6):701-712, November 1980.

As part of the Bogalusa (Louisiana) Heart Study, a comprehensive program to assess cardiovascular disease risk factor variables for an entire biracial pediatric population, a study of cigarette smoking was conducted from September 1976 to June 1977 using a sample of 3,014 children in grades 3-12. A questionnaire was administered to obtain data on attitudes, beliefs, and cigarette-smoking behavior. For all sex and race groups in the study, the percentage of smokers increased with age. White males were exposed to smoking and adopted smoking earlier (32 percent of 14- to 15-year-olds) than did white females, yet females in the 16- to 17-year age range adopted smoking at a higher rate (41 percent) then did males. By age 14 to 15, white smokers consumed a pack a week on an average, increasing to almost two packs a week by age 16 to 17. The number of cigarettes smoked by blacks was less than that smoked by whites at all ages. The percentage of nonadopters (those who had a regular habit but quit) increased with age, peaking earlier for girls than for boys. More information should be gathered about why children pass from nonsmoker to adopter, and detailed study of the experimental nonadopter category of children, which was largest in the 12- to 13-year-old age group, might provide some of that information. Intervention and prevention programs should be designed to identify experimental nonadopter children and reinforce their behavior. 29 references.

81-1718
A Study on the Nutrition Information Needs of Some Community Workers in Regions II and IV.
Jose, A. M.
Philippine Journal of Nutrition 30(4):193-204, October-December 1977.

A study involving 96 home management technicians (HMT's) assigned to 2 regions in the Philippines investigated the amount of nutrition material reaching the workers, uses made of and reliability of the material, and type and quantity of other nutrition information materials needed. Questionnaires were mailed to 147 subjects in February, March, and April 1977. Data from the 96 respondents indicated that (1) most HMT's thought that availability of nutrition education material was limited; (2) most material was considered useful, particularly in motherhood classes; (3) most material was in the form of pamphlets; (4) major sources of material were government agencies and private organizations, and the Nutrition Research Institute and the Bureau of Agricultural Extension were the leading sources; (5) coworkers were the primary sources of information regarding availability; (6) almost all respondents obtained their material at conferences, seminars, or training courses; (7) posters, pamphlets, manuals, and leaflets, in that order, were the most popular information formats; and (8) the nutritive value of foods, low-cost recipes, and diets for vulnerable groups were the most sought after subject areas. 7 references.

81-1719
Status of Coronary Heart Disease Risk Factors.
Kannel, W. B.
Journal of Nutrition Education 10(1):10-14, January-March 1978.

The latest findings about various coronary heart disease (CHD) risk factors are reviewed. Although the major identified risk factors do not entirely explain the variance in incidence of CHD between and within populations, they can identify vulnerable segments of almost any population, thus enabling physicians to initiate preventive approaches. The impediments to prevention and intervention efforts are the remoteness of the threat in time, ignorance about the threat of risk factors in childhood and the need to begin prophylaxis early in life, questions about the safety of the recommendations, and the need for more effective means of intervention. Elevated blood pressure is one major controllable risk factor that is detected easily and for which excellent therapy is possible. Compliance with hypertension treatment may be enhanced by careful and gradual institution of therapy, simple regimens, insurance against costs, individualized management, public education, and better systems of followup. Although the best time to begin CHD prophylaxis is not firmly established, corrective measures instituted later in life are known to be of only limited value. Although there is no absolute proof that proper diet, weight control, exercise, blood pressure control, blood lipid control, and smoking cessation will in fact lower CHD incidence, there are indications that these interventions work. 63 references.

81-1720
A Study of the Predictive Validity of the Health Hazard Appraisal.
Kramer, D. G.; Wiley, J. A.; and Camacho, T. C.
Atlanta, Ga., Epidemiology Officer, Bureaus of Epidemiology and Health Education, Center for Disease Control, 30 p., October 1980.

Questionnaire data collected from approximately 6,600 residents of Alameda County, California, in 1965 were used to assess the predictive validity of the health hazard appraisal (HHA), a method of estimating an individual's risk of death over a 10-year period. Researchers filled out HHA questionnaires using the 1965 data, and resulting risk estimates were then compared with the actual morbidity and mortality within the sample for the period 1965-74. Data analysis indicated that a simple measure of risk derived from the HHA (specifically, the difference between chronological age and appraised age) correlated positively with the mortality experience of the sample. The HHA measure also correlated positively with four different indicators of overall health status of the sample of survivors in 1974. It appears that the nondemographic factors associated with family and personal health history and various discretionary behaviors make distinct, significant contributions to the prediction of ill health and death. Since the study did not have all the data necessary for full HHA assessment, other research designs should be implemented to determine the exact level of accuracy of the HHA and means of improving accuracy.

81-1721
A Pilot Study of the Results of a Cancer Education Program on the Attitudes of Dental Students.
Lee, M. M.; Gardiner, j. F.; and Legett, B. J.
Journal of the Louisiana Dental Association 39(1):17-19, Spring 1981.

A pilot study at the Louisiana State University School of Dentistry was conducted to assess the efficacy of a clinical cancer education program on students' attitudes toward three preselected concepts: (1) "Cancer Education," to assess attitudes toward the program as a whole; (2) "My Experience With the Cancer Patient," to measure potential attitudinal change induced by students and patient interaction; and (3) "Myself," which served as a control. The program was established in 1975 by the school in cooperation with the National Cancer Institute. Eighty-nine students participated in the program and completed assessment questionnaires before their clinical cancer experience; 65 students completed the program. The clinical portion of the program included small-group orientation sessions with medical residents, exposure to patients with oral cancer or some other type of head or neck cancer, and small-group sessions at the Maxillofacial Prosthodontic Clinic. Students assessed the behavioral effects of cancer and its treatment on patients by using a structured interview technique. Case presentations were made by faculty or postdoctoral students. The community-based portion of the program consisted of students conducting oral cancer screening examinations under the supervision of an oral pathologist. After clinical experience, the students' attitudes were assessed using the semantic differential method, which employed a rating scale to assess the intensity the 65 respondents felt toward the preselected concepts. Data indicated that the program resulted in positive changes in students' attitudes toward patients with cancer, and students were pleased with the program as a whole. 11 references.

81-1722
The Smoking Problem: A Review of the Research and Theory in Behavioral Risk Modification.
Leventhal, H. and Cleary, P. D.
Psychological Bulletin 88(2):370-405, September 1980.

A review of the literature on smoking initiation, maintenance, and therapy in children and adults reveals valuable theoretical and practical implications for future studies in this area. Field studies of antismoking programs have included small-scale communication experiments, school studies, and community studies. General trends in such studies indicate that (1) recent increases in success rates may be due to changes in the social environment that multiply the action of previously unsuccessful procedures; (2) current interventions are based on communication and behavioral models that ignore features unique to smoking; (3) methodological refinements of current interventions are unlikely to increase success rates significantly; (4) prevention studies should be directed toward critical steps in the developmental history of smoking, such as preventing initial attempts to smoke, facilitating negative interpretations of initial attempts, and retarding regular use; and (5) studies of cessation and withdrawal must consider findings and theories of nicotine dependence. Future studies should account for the four distinct stages of smoking, namely, preparation for the smoking experience, initiation of the smoking habit, establishment of the habit, and maintenance of the habit. Development of a hypothesis to account for the development of craving conditioned to internal and external cure provides suggestions for means to eliminate the craving. Numerous references.

81-1723
Nursing Care of Oncology Patients Receiving Chemotherapy.
Lum, J. L. J.; Chase, M.; Cole, S. M.; Johnson, A.; Johnson, J. A.; and Link, M. R.
Nursing Research 27(6):340-346 November-December 1978.

A study was undertaken to explore relationships between selected nursing activities and outcomes for oncology patients who were receiving chemotherapy as part of a research effort to identify nursing activities related to the subsequent health status of patients. The subjects were 57 patients from oncology and medical units in public and private general hospitals. Data were collected primarily via patient and nurse responses to self-administered questionnaires. In the first phase of data analysis, zero-order correlations were obtained for each pair of nursing activity and patient outcome variables. To identify relative contributions of different nursing activities to the health status of patients, regression analyses were performed in selected situations. The content and quality of the treatment explanation and care regimen were correlated positively with patients' self-esteem. The quality of the explanation also correlated positively with patients' knowledge. The more involved patients were in planning their daily activities, the more important it became for these patients to have things explained to them. Numerous references.

81-1724
Inconsistencies in the Evaluation of Selected Alcohol Education Materials.
Martin, G. L.; Newman, I. M.; and Hanus, R. D.
Journal of Drug Education 11(1):53-60, 1981.

The Nebraska Alcohol Information Clearinghouse convened panels of experts to evaluate 10 frequently requested alcohol education pamphlets in regard to 5 criteria. A 28-member program-planning task force developed a rating instrument that consisted of six 6-point semantic differential scales designed to evaluate each pamphlet's message, content, form, cost, and overall acceptability. The task force was then divided into two panels based on residential status and workplace. The widely differing responses from 15 panelists suggested that evaluation of educational literature by panelists may not be a valid method of assessing the value of such literature. Though consensus might have been improved by increasing the panel size, providing a more detailed definition of evaluation criteria, or using a more homogeneous population of raters, the improvement in consensus would have been more statistical than real. To remedy this problem, developers of educational materials should outline a clear statement of specific educational objectives and a carefully defined target group for each item. These practices would produce a measure of accountability for document producers. A list of pamphlets rated in the study is appended.

81-1725
Dental Health Education. (Letter)
McCallion, P. L.
British Dental Journal (London) 147(6):156, 1979.

Improvement in overall dental health in Britain, including reductions in the loss of natural teeth, has discredited claims by critics of the dental profession and prepared the way for preventive strategies. The improved dental health of the British population has been certified by the preliminary results of the Adult Dental Health Survey conducted in 1978 by the Royal Commission. Attacks on dental professionals for relying on reparative, rather than preventive, techniques have proven to be unwarranted. Dentists of the previous generation were given the task of convincing the public of the advantages of natural teeth over artificial teeth. Having largely achieved this task, older dentists have provided today's dentists with a population that values natural teeth and is willing to follow preventive care measures prescribed by their dentists.

81-1726
Partnerships for the Future in Preventive Health Care (Turn Around, Look At Us).
McCracken, B. E.
Journal of the Florida Medical Association 67(9):817-825, September 1980.

Findings of the 1979 Lifestyles-Personal Health Care in Different Occupations Study, carried out by the American Academy of Family Physicians, suggested that physicians must help the public accept responsibility for health care. The 72-question survey contained items on nutrition, weight control, exercise, medical care, work environment, home environment, tobacco and alcohol use, drug use, sexual activity, and demographics. The survey was sent to members of the American Management Association, the American Academy of Family Physicians, the National Grange, the National Secretaries Association, the International Ladies' Garment Workers Union, and the American Federation of Teachers. Data from the 4,473 respondents indicated that (1) fewer people were satisfied with physician interest than with physician services; (2) the typical physician is overweight; (3) 35 percent of the physicians work more than 60 hours per week; (4) women are less content with their work and work environment than men; (5) physicians have fewer problems at home than did the other groups surveyed; and (6) the typical physician does not smoke cigarettes or marijuana, never uses hard drugs, drinks little alcohol, and has few health problems. The findings suggest that greater attention should be paid by physicians to patient coping and physician modeling skills.

81-1727
Factors Associated with the Maintenance of Positive Health Behavior.
Mechanic, D. and Cleary, P. D.
Preventive Medicine 9(6):805-814, November 1980.

A 16-year followup of a study involving 302 fourth- and eighth-graders in Madison, Wisconsin, was undertaken to assess various factors associated with positive health behavior. The children's mothers were interviewed at home, while data from the children were obtained at school. The original survey, which involved 350 mother-child pairs, was conducted in 1961, and the followup study, which involved 302 of the grown students, was conducted in 1977. The dependent variable, an eight-point scale of positive health behavior, was based on measures of health behavior and scales of health response. The components of the index assessed risk-taking behavior, emergency preparations, drinking behavior, smoking behavior, preventive medical care, physical activity, and exercise. The index was made up of both individual items and scales. Women had more positive scores than men, reflecting a higher level of drinking and risk-taking and a lower level of preventive medical behavior among men. Other predictors include education and a conventional behavioral orientation. Positive health behavior is associated with both psychological well-being and subjective health status. The patterns of associations found support the hypothesis that positive health behavior is part of a complex lifestyle that may reflect the ability to anticipate problems, mobilize to meet them, and cope actively. 18 references.

81-1728
Effect of an Instructional Motivation Program on Oral Health in Danish Adolescents After 1 and 2 Years.
Melsen, B. and Agerbaek, N.
Community Dentistry and Oral Epidemiology (Copenhagen) 8(2):72-78, April 1980.

A 2-year study of the effects of an intensive motivation program in oral health for 11- to 15-year-old schoolchildren was conducted in a Danish town. The experimental preventive program, administered by a dental hygienist, consisted of small-group sessions during which maximum effort was made to encourage active involvement of the children. Methods used included lectures, games, experiments, and discussions. At the end of the first year, a multiple-choice test, designed to measure the level of knowledge and attitudes toward dental care, was administered to experimental and control groups. The children were also asked to write evaluation essays about the program. After one year, the experimental group was supplemented by two new student groups who, in addition to receiving the motivation intervention, competed with each other to determine which one could attain the highest level of oral health. Blind clinical examinations were performed on all subjects. Data from tests, essays, and clinical examinations indicated that, while the program reinforced existing positive attitudes toward dental health, the children's cognitive level improved only slightly, and the oral health of the experimental-group children did not improve. 25 references.

81-1729
Public Opinion and Perceptions of Recommendations Used in Nutrition Education.
Rae, J. and Nielsen, H.
Journal of the Canadian Dietetic Association (Toronto) 41(2):85-92, April 1980.

Personal interviews with 1,614 subjects over 18 years old were conducted in January and February 1979 in British Columbia, the Prairie provinces, Ontario, and the Atlantic provinces of Canada to obtain information on public opinion and attitudes towards nutrition recommendations. Adopted by Health and Welfare Canada, these recommendations include the consumption of a nutritionally adequate diet; a reduction of fat intake to 35 percent of total calories and the use of polyunsaturated fats; a diet emphasizing whole grains, fruits, and vegetables and minimizing alcohol, salt, and refined sugars; and the prevention of obesity by reducing caloric intake and increasing physical activity. The recommendations have been accepted as standards by the Federal, Provincial, and Territorial departments of health, and over 50 national associations representing health, fitness, the food industry, agriculture, and consumers have been informed of them. In 1978, the Canadian Heart Foundation and the Provincial departments of health began a campaign to increase public awareness of the recommendations. Analysis of the interview data indicated that differences across the four regions were minor. The responses generally demonstrated respect for nutrition, a trend by individuals to improve their eating habits, an appreciation for "sensible" eating and its benefits, and a greater acceptance of recommendations and advice when presented in positive terms. The study further indicated that the public has some misconceptions about snack foods; an awareness of how the cost of food affects dietary choices; and an awareness of a relationship between (1) diet, exercise, and weight control, and (2) overall well-being. Respondents identified parents and family members as the main sources of nutrition information and emphasized the importance of physicians and teachers as nutrition information sources. 5 references.

81-1730
Women's Smoking Trends and Awareness of Health Risk.
Tagliacozzo, R. and Vaughn, S.
Preventive Medicine 9(3):384-387, May 1980.

To test the hypothesis that awareness of the risk of smoking and personal vulnerability may not be as strong in female smokers as in male smokers, 276 adult smokers in Ann Arbor, Michigan, were surveyed on their awareness and knowledge of the recent Surgeon General's Report on Smoking and Health, their perception of personal risk, their present and past smoking behavior, and their estimate of the comparative risk of heart disease and lung cancer. The smokers ranged from 18 to 72 years old, with 72 percent of the sample 40 years old or younger. Nearly half the subjects had received between 13 and 16 years of education, 24 percent had 12 years or less, and 28 percent more than 16 years. Twenty-eight percent smoked 10 cigarettes or less per day, 39 percent between 10 and 20 cigarettes, and 33 percent more than 20. The results indicated no marked sex difference in awareness of the Surgeon General's Report, but showed that significantly more female than male smokers worried about what they heard and read about smoking risks. Females tended to think that the health risks from smoking were greater for men than for women, particularly in the areas of lung cancer and heart disease, thus suggesting that women's feelings of personal vulnerability may be less than men's. Due to the small sample size and lack of statistical significance of the differences, study results do not prove conclusively whether women are less aware then men of the risk of smoking or whether they feel less vulnerable than men, although such a trend is suggested by the data. 12 references.

81-1731
Validity and Reliability Issues in Measurement Instrumentation.
Talmage, H. and Rasher, S. P.
Journal of Nutrition Education 13(3):83-85, September 1981.

Validity and reliability measures are reviewed, and several approaches for measuring and improving these measures are discussed. Instruments vary with respect to intended data source, response format, and collection mode, and researchers must consider research purposes, target population, and uses of information to be collected when devising or choosing an instrument. Test developers must be aware of all four types of validity, namely, content, face, criterion, and construct. A reliable instrument is one that yields a similar score upon repeated administrations when all error sources are kept the same. Test developers measure reliability in terms of stability, equivalence, split-half reliability, and internal consistency. Finally, the items in an instrument must be checked for readability and submitted to item analysis procedures, such as the difficulty index, discrimination index, and item-to-item test correlation. 7 references.

81-1732
Relationships Between Drug Knowledge and Drug Attitudes for Students in Large, Intermediate, and Small Schools.
Whiddon, T. and Halpin, G.
Research Quarterly 48(1):191-195, March 1977.

Attitudes toward alcohol, amphetamines, barbiturates, heroin, LSD, marijuana, and tobacco were surveyed for 300 12th-grade students randomly selected from large, intermediate, and small public high schools. The subjects completed the Drug Knowledge Test and a semantic differential scale, and the resulting data were analyzed using Pearson and multiple correlation procedures. Study results show that knowledge does not ensure negative attitudes toward drugs; for the total sample, significant positive correlations that involved amphetamines and LSD and a significant negative correlation that involved alcohol were found. Although school size and sex did moderate the magnitude of the relationships between knowledge and drug use in the case of LSD, tobacco, and marijuana, the correlations for the subjects grouped by sex and school size tended to reflect the correlations for the population. Drug education for 12th grade students that emphasizes knowledge may not be achieving the desired goals. In some instances, drug education programs may need to be different for males and females and for students in large, intermediate, and small schools. 7 references.

81-1733
The Relationship Between Assertiveness, Conformity, and Drug Use.
Williams, J. M.; Scott, A. J.; Stout, J. K.; and Hertzel, R.
Journal of Drug Education 11(1):47-51, 1981.

Sixteen students attending the University of Scranton in Pennsylvania were studied to investigate the relationship between the students' drug use behavior and their tendencies toward assertiveness or conformity. The subjects were exposed to a series of 10 conformity tasks based on Asch's classic paradigm. This measure entailed exposure of the subjects to 10 visual discrimination tasks. Before a subject's response, four confederates gave either a correct or bogus response, and the subject's consistency with that response was noted. Immediately following completion of this measure, subjects were asked to complete a 50-item paper and pencil measure of self-reported willingness to use drugs (the Tentative Drug Use Scale). Assertiveness and conformity scores were blocked on alcohol and marijuana use versus use of "hard" drugs. One-way analysis of variance performed on resulting data indicated that alcohol and marijuana users were less assertive and more compliant than users of hard drugs. Thus, assertiveness training might increase subjects' ability to extricate themselves from situations in which social conformity leads to drug use. Unfortunately, indiscriminate use of assertiveness training could encourage already assertive individuals who have experimented with hard drugs to increase their use of such drugs. 16 references.

RISK REDUCTION

81-1734
Behavioural Change for the Prevention of Oral Diseases in Children: A Symposium.
International Dental Journal (The Hague) 30(3):234-286, September 1980.

A recent symposium of dental health professionals was held to (1) illustrate specific examples of dental health education programs for children currently being implemented in Australia, Denmark, and the United States and (2) integrate these illustrations with findings and recommendations from the behavioral and social science research literature concerning changing dental health behavior. The one-to-one approach, the small group approach, and the structural approach (altering the structure of the dental care delivery system) were examined. Two papers were delivered on each approach. Topics included use of the one-to-one approach to educate and motivate children in a typical practice, principles that underlie motivation to improve oral health, use of a small group approach for schoolchildren in Australia, principles that underlie motivation tactics used with groups, changes in the structure of the dental care delivery system in Denmark, and the relationship between a country's dental care delivery system and the oral health of its children. Numerous references.

81-1735
Health Education Using Microcomputers: Initial Acceptability.
Ellis, L. B. M. and Raines, J. R.
Preventive Medicine 10(1):77-84, January 1981.

A study involving 420 volunteers with little or no experience with computers was conducted to evaluate the effectiveness of 4 computer programs in increasing the public awareness of good health habits. One computer program addresses risk factors for coronary heart disease and another addresses desirable weight and weight control; two more programs promote more general health concerns. The four computer programs, an introduction to the computer, the list of programs, and related utility routines are stored in less than 100,000 characters on one mini-floppy disk. The programs request lifestyle and health status information from the subject and provide the subject with information on ways of altering lifestyle to improve health. The study was designed to include 96 unassisted users and 324 users who were assisted by an aide during a 3-day health fair. The study demonstrated that computer-assisted instruction on health material is

acceptable to persons unfamiliar with computers. Of the more than 20 exhibits at the fair, the health awareness programs were among the most popular. Assessment of program evaluations by users indicated that assisted users felt the programs to be more helpful than unassisted users. Quantitative or mathematical approaches to life expectancy probabilities produced more anxiety than qualitative or general approaches. 8 references.

81-1736
Hypertension Counseling.
Fairchild, C.
Occupational Health Nursing 27(5):25-29, September 1979.

An effective counseling program begins with hypertension detection through accurate blood pressure measurement. Blood pressure can be artificially elevated by cold, exercise, emotional upset, a recent meal, cigarette smoking, and improper measuring techniques. Previously diagnosed hypertensives, and the untreated patients, should be educated when patients are receptive to learning about the disease. Nurses and other counselors should explain the five prescriptions for the control of hypertension: weight reduction, a low sodium diet, reduction of stress, drug therapy compliance, and exercise. Hypertension patients generally lack information and have misconceptions about their disease and therapeutic requirements. Patients fear drug dependency and uncomfortable side effects and frequently believe that once blood pressure falls to a normal range they are cured. Patients must be educated about the chronic nature of the disease and encouraged to participate actively in monitoring and treating the disease. The Community Hypertension Evaluation Clinic (CHEC) program informs the public of the threat of hypertension, screens people at 1,171 sites across the country, and estimates that 55 percent of the population has undetected, untreated, or uncontrolled hypertension. 8 references.

81-1737
Primary Prevention Services for Children and Youth.
Gilchrist, L. D.; Schinke, S. P.; and Blythe, B. J.
Children and Youth Services Review 1:379-391, 1979.

A model for primary prevention of social and health problems among children and youth has been developed and field tested as a means of preventing smoking and unwanted pregnancies among teenagers. The model has three components, which focus on information dissemination, information personalization, and skills acquisition; the components are delivered through a group-training format. The first field application of the model involved 36 high school sophomores who were divided into control and treatment groups. Treatment groups were led by a male-female team of graduate-level social workers who met with the groups for twice-weekly, 50-minute sessions over a 7-week period. The second field application involved 56 sixth-grade students involved in a similar program of eight 60-minute sessions. The first and second experiments dealt with prevention of unwanted pregnancy and smoking onset, respectively. Each intervention program began with sessions during which information was provided, followed by sessions during which students applied the information in specific written and interpersonal exercises within the group and outside the group. Data from pre- and postprogram tests document the feasibility and effectiveness of the model. Self-report, behavioral, and objective data obtained at the end of the program and 6 months later indicated that trained youths used contraceptives more frequently and smoked less than untrained youths. Provision of preventive skills can be combined with numerous other intervention strategies in similarly beneficial ways. Numerous references.

81-1738
The Belgian Heart Disease Prevention Project. Modification of the Coronary Risk Profile in an Industrial Population.
Kornitzer, M.; De Backer, G.; Dramaix, M.; and Thilly, C.
Circulation 61(1):18-25, January 1980.

The Belgian Heart Disease Prevention Project is a controlled, multifactorial prevention trial involving 19,390 males, 45 to 59 years old, employed by 30 Belgian industries. The industries were paired and randomized into control and intervention units. In each factory in the intervention unit, the subjects from the two highest deciles of a coronary risk-score distribution curve were given individual counseling twice a year, and a health education campaign was organized. A random sample of 10 percent of the subjects working in factories in the control unit and all subjects working in factories in the intervention unit were provided with base-line physical examinations. After 2 years, high-risk subjects and the randomly selected control and intervention subjects were compared regarding coronary risk by means of a multiple logistic function (MLF). In the intervention high-risk group, the MLF showed an overall decrease of 20 percent, while in the control group there was an overall increase of 12.5 percent. Comparing the random samples, an increase of 25 percent was found in the control group, while a drop of 2.26 percent was found in the intervention group. It appears that the coronary risk profile can be altered in groups of middle-aged male employees through mass

media health education interventions supplemented by face-to-face counseling for high-risk subjects. A listing of staff members of the project is appended. 20 references.

81-1739
Skills Training in a Cardiovascular Health Education Campaign.
Meyer, A. J.; Nash, J. D.; McAlister, A. L.; Maccoby, N.; and Farquhar, J. W.
Journal of Consulting and Clinical Psychology 48(2):129-142, 1980.

As an integral part of a communitywide health education project, four subsamples of persons at higher than average risk for cardiovascular disease were identified at a baseline survey in three California towns and were observed during three annual followup surveys. Interventions were designed to reduce the risk of heart disease by increasing knowledge of risk factors and modifying dietary, smoking, and exercise behavior and various physiological indicators of risk. A mass media campaign was administered to three groups. One of these groups was also given face-to-face instruction with techniques derived from social learning theory and behavioral self-control principles such as self-observation, modeling, and token reinforcement. The fourth group served as the control. Some significant risk reduction took place among all groups of treated subjects as the subjects' knowledge of risk factors increased and as their lifestyles improved. According to some measures, greater and longer lasting changes took place in the group provided with face-to-face and mass media instruction. These findings indicate that the media alone have the power to influence the risk of heart disease and some related behaviors. When media campaigns are supplemented by face-to-face instruction, however, a wider range of behavior is modified. 35 references.

81-1740
Behavioural Change for the Prevention of Oral Disease in Children: One-on-One Programme.
Page, J.
International Dental Journal (The Hague) 30(3):236-239, September 1980.

One-to-one oral health education counseling is one of the most common and effective means by which dentists and hygienists can influence their patients' oral health behavior. It is also cost effective for the patient. To improve the dental health of children, parents and children should be informed about the need to apply fluoride topically during childhood, reduce the consumption of sugar, and control plaque by brushing and flossing. Fluoride supplements should be suggested for children and expectant mothers in areas where water supplies contain low levels of this mineral. Diet and oral hygiene methods should be discussed at each oral examination, with reinforcement of good oral health behavior through positive feedback. Parents should be encouraged to be present during examination of their children so that they can be informed of any problems that require attention. Educational interventions should be conducted by the dentist or hygienist, since they possess sufficient authority to influence the behavior of parents and children. 15 references.

81-1741
Health Knowledge and Community Prevention of Coronary Heart Disease.
Puska, P.; Vienola, P.; Kottke, T. E.; Salonen, J. T.; and Neittaanmaki, L.
International Journal of Health Education (Geneva) 24(2, Suppl.):11 p., April-June 1981.

A questionnaire and physical examination protocol were administered to two independent random samples of people born between 1913 and 1947 living in North Karelia, Finland, to evaluate the effectiveness of the North Karelia Cardiovascular Disease Community Control Project. The project, which began after the first survey in 1972, was a community-based effort to lower the population's risk of coronary heart disease. It involved a campaign to change dietary practices and a systematic hypertension detection and treatment program. Using the existing community structure, the intervention plan involved general health education for the population via various media, organization of individual and group services, promotion of environmental changes, and instruction of local personnel. An evaluation sample comprising 6.6 percent of the population was taken in 1972 and 1977. The 24-item health knowledge questionnaire was designed to obtain information concerning hypertension and cardiovascular disease, diet and serum cholesterol, smoking, and physical activity. The test was also administered to comparable samples in a reference area outside North Karelia. Data from the surveys indicated that, though the program had only slight positive influences on the population's health knowledge, the population's health behavior improved significantly. Similar findings have been reported by Belgian researchers. 22 references.

81-1742
Into the Mainstream--With Health Risk Reduction. Proceedings of the Fifteenth Annual Meeting On Prospective Medicine and Health Hazard Appraisal. St. Petersburg, Florida; October 3-6, 1979.

Society of Prospective Medicine, Indianapolis, Ind.
Bethesda, Md., Health and Education Resources, 84 p., February 1979.

The American College of Preventive Medicine and the Society of Prospective Medicine cosponsored the 1979 annual meeting on prospective medicine and health hazard appraisal (HHA) in St. Petersburg, Florida. The objectives of the meeting were to (1) acquaint newcomers with health risk appraisal theory and practices; (2) provide a forum for sharing experiences of applying health risk appraisal in diverse settings; and (3) promote informal exchange among those working with health risk estimation and health education. The content of the presentations included (1) an analysis of the scientific evidence of risk in relation to cardiovascular disease; (2) an epidemiologic approach to gaining new knowledge, and the need for randomized clinical trials to document the effectiveness of intervention techniques; (3) a historical account of the effectiveness of prevention in reducing the incidence and prevalence of disease from 1900 to 1970; (4) a discussion of the Canadian Government's efforts to improve the health of its residents; (5) discussions of the origins of the 1960's movement in which health was revered as a positive value, the Federal Government's initiatives in promoting health, and alternatives to Federal solutions for healthful living; (6) an evaluation of a prospective study of risk appraisal, including a discussion of the Well Aware About Health project that incorporates epidemiologic approaches to evaluate program effectiveness; (7) descriptions of a new health estimation technique which includes morbidity and mental health components, the relationship between family health and the health status of parents, and the HHA as a stimulus to behavior and attitudinal changes; and (8) the use of public funds for risk appraisal. Research is needed to demonstrate the effectiveness of disease intervention by modifying risk factors; if HHA is to be viewed as credible, a better epidemiologic base of prevalence and incidence of risk factors is needed.

81P-1743
Iowa State University Alcohol Education Program.
Krafft, J.
Iowa State University, Office of Student Life, 206 Student Services Building, Ames, IA 50011
Funding Source: Iowa State Dept. of Substance Abuse, Des Moines.
1977 - Continuing.

The Alcohol Education Program at Iowa State University is designed to teach students to make responsible decisions about alcohol use and to alter the drinking environment in order to promote responsible decisions. Guest speakers in related academic courses, seminar classes on alcohol education, dinner programs in residences, evening programs, and workshops are offered to students who choose not to drink, students who choose to drink but do not regularly suffer serious consequences from their alcohol use, and students who have developed alcohol problems. To promote the program, advertisements were run in the school newspaper, and handouts were distributed, entitled "The Counter-Cocktail: Spirited Drinks Without the Spirits," and "A Guide to Responsible Hosting." A training manual, "An Introductory Guide to Alcohol Use and Abuse," was written to train student resident assistants, the counseling service staff, and the student affairs staff. Evaluation forms filled out by participants have shown attitude and behavior changes, which students attributed to the course; awareness of individual patterns of consumption as well as those of others; and some student success at controlling drinking. The steady increase in the number of students with alcohol problems who have been referred to the program is an indication of the program's success. The referral network consists of resident assistants, the health service, instructors, student groups, and campus media.

81P-1744
Prevention Education Training-Alcohol Resource Center.
Pressley, G.
Nassau Community College, Student Personnel Services, Building P, Lower Level, Garden City, NY 11530
1972 - Continuing.

The Prevention Education Training program at the Alcohol Resource Center of Nassau Community College in Garden City, New York, is designed to provide the college community and county high school students with education about alcohol use, abuse, and alcoholism; develop criteria for alcohol referrals for the college community and county high schools; offer a meeting place for self-help groups; use media as an educational tool; offer special lectures on alcohol to college classes, clubs, and faculty; and offer specialized peer programs to college and high school students and faculty. The staff was recruited through a college volunteer fair, community health classes, the college newspaper, class presentations, referrals, and college field placement. A radio show, a media library, a training program for college students to deal with alcohol problems, peer counselor training, college classes on alcohol use, dissemination of materials on alcohol, and off-campus lectures have been implemented. Al-Anon and Alcoholics Anonymous both meet on campus. Evaluation by training-group observation, staff interviews, and staff program reports is performed by the dean of students and program staff, yet no funds have been budgeted for evaluation.

SCHOOL HEALTH EDUCATION

81-1745
Attitude Change and Death Education: A Consideration of Goals.
Agatstein, F.
Death Education 3(4):323-332, Winter 1980.

Quantitative measures of the impact of death education courses may fail to encompass unexamined assumptions about "proper" attitudes toward death. The major criterion for the evaluation of death education courses is usually the reduction of anxiety concerning death. Research indicates that students' anxiety levels about death before taking such courses are not pathologically high. Placing views of death into quantitative categories according to levels of anxiety neglects the symbolic importance of these views; rather, educators should examine and classify feelings according to their qualitative differences. An examination of the possible relations between attitudes and psychological experiences within the framework of Lifton's concept of the psychoformative process indicates that death education courses should attempt to increase students' symbolic engagement with death rather than reduce fear or instill so-called favorable attitudes. 14 references.

81-1746
Cooperation Between Schools and Community for a Continuum of Chemical Awareness Services.
Borea, M. and Loewenson, D.
Paper presented at the meeting of the National School Boards Association (San Francisco, Calif., April 19-22, 1980), 6 p., April 20, 1980.
Available from: ERIC; Order No. ED-191 659.

The development and implementation of the Minneapolis Public Schools Chemical Awareness Program (MPSCAP) is discussed. The program is based on the premises that (1) adolescent drug abuse is a community problem; (2) school districts cannot be expected to bear the entire burden of prevention activities; (3) the school is not the proper setting for primary prevention; and (4) intervention with drug abusers must be supported by active participation of parents and the community. Differential services should be available to respond to the varying levels of drug use in the student population. Essential program components include assessment and intervention services for dysfunctional abusers, in-school group counseling services, a sequential curriculum on chemical awareness and decision making throughout primary and secondary grades, periodic information programs for parents and other community members, parental support groups, a drug education training program for staff, and clearly stated guidelines for dealing with drug abuse throughout the school district. Using 24 full-time chemical dependency professionals, MPSCAP established its credibility through pilot programs at 1 junior high and 1 senior high school. It has since expanded into a model prevention program.

81-1747
Yes, You Can Have a Health Service in a Community College.
Busky, H. F.
Paper presented at a Meeting of the American College Personnel Association (Denver, Colorado, March 29, 1977), 56 p., March 29, 1977.
Available from: ERIC; Order No. ED-167 213.

The health services program at Prince Georges Community College in Maryland offers preventive and educational services as well as referral for and treatment of minor illnesses and injuries. Services include individual health counseling, first aid, assistance to the handicapped, a health awareness program, cardiopulmonary resuscitation training, video presentations to instruct students and staff in handling emergencies, blood donation programs, physical examinations for athletes, and a health education and service club. The program is staffed by the supervisor of health services, a staff nurse, a medical consultant, a part-time relief nurse, and a health room assistant. Staff activities are evaluated via assessment forms completed by students, counselors, and supervisors. An outline of the Maryland Nurse Practice Act, copies of the confidential student health form and the nursing health report form, and a report on a nurses' workshop are appended. 11 references.

81-1748
The Goal of Abstinence: Implications for Drug Education.
Chng, C. L.
Journal of Drug Education 11(1):13-18, 1981.

The failure of school drug education programs in the United States may be linked, in part, to such programs' commitment to the goal of abstinence from drug use. After the failure of early scare tactics, many of which relied heavily on sensationalism and fabrication, a wide variety of sophisticated programs have emerged. Recent programs have involved provision of information, values clarification techniques, decision-making components, self-concept development, development of social alternatives to drug use, and numerous other techniques. Though the goal of abstinence is sometimes concealed in vaguely

enunciated program goal statements, scrutiny of program objectives nearly always results in the discovery of this aim. In a society that promotes drug use for every discomfort and problem, total cessation of all drug experimentation is not a realistic goal for an educational program. Pressure from funding sources, however, forces planners to emphasize abstention as the ostensible goal of all programming. To mask the resulting failure to achieve this goal, or even reduce drug usage, drug education programs have become deficient in evaluation components and in expression of clear goals. Setting a goal of abstinence involves ignoring influences on the student outside the school, the drug educator's need for credibility in the eyes of the students, and the diversity of the student population. 28 references.

81-1749
Activity Guide for Nutrition Education, Grades K-3. "I Am What I Eat."
Chula Vista City School District, Calif. Nutrition Education Project BUILD.
Chula Vista, Calif., the District, 68 p., 1978.
Available from: ERIC; Order No. ED-174 570.

Activity guidelines for nutrition education programs at the elementary school level are offered for use by teachers and administrators. The lesson plans contain activities that address food choices, factors influencing choices, consumer competencies, food-related careers, and food protection. Each lesson plan provides information on objectives, learning experiences, resource materials, and extension areas.

81-1750
Teacher Activity Package: Drug Information. Grades 2-6.
Cooperative Educational Service Agency Number Eight, Appleton, Wisc.
Appleton, Wisc., the Agency, 73 p., October 1977.
Available from: ERIC; Order No. ED-167 908.

Materials for teachers to use in elementary and junior high school drug education programs are provided. The goal of the package is to promote the proper use of drugs by students and to help them consider the propriety of using or abusing drugs. It emphasizes use of factual materials in conjunction with activities that help students learn about themselves, their values, and decision making. Activities are geared toward enabling students to understand drug substances, definitions of drug abuse, classifications of household drugs, and the effects of major drugs. Several activities are designed to help students understand the influence of advertising and the media on drug use.

81-1751
I Cooked It Myself! A Nutrition-Cooking Handbook.
Cramer, J. K.
Windsor, Calif., Resources for Communication, 103 p., 1980.

Guidelines for implementing a year-round nutrition education program for children through single-portion cooking are provided for use by California elementary school teachers and their students. Topics include establishment of a nutrition and cooking program in the classroom; safety requirements; facts and recipes for developing students' understanding of plants, nutrients, fiber, and micro-organisms and enzymes in the diet. Special materials provided include recipes, information panels, notes, two-page graphic spreads, display materials, and an index.

81-1752
Health Education Survey.
Demak, L. S.
Detroit, Mich., Wayne County Intermediate School District, 21 p., 1979.
Available from: ERIC; Order No. ED-175 827.

A health education survey instrument used in the Wayne County, Michigan, Intermediate School District is presented for use in identifying major health topics taught, grade levels at which these topics are taught, and number of class periods devoted to each topic. A section is included for information on grade level and subject area in which major health concepts are the topic of instruction.

81-1753
Drug Education Program.
Department of Defense, Washington, D.C. Dependents Schools.
Washington, D.C., the Department (DS Manual 2720.3), 9 p., February 13, 1978.
Available from: ERIC; Order No. ED-172 086.

The Department of Defense has developed guidelines for developing drug education programs in schools on overseas military bases. The recommended curricula include (1) a program for primary grades that stresses mental and physical health, with emphasis on developing self-esteem in the child; (2) a program for grades 4-6 that covers individual differences, the qualities of a worthwhile person, the relationship between mental health and personal actions, and the effects of tobacco and alcohol use; (3) a program for grades 7-9 that emphasizes values clarification, decision making, and individual and community responsibility; and (4) a program for grades 10-12 that reviews the effects of drug use as well as related legal,

social, and psychological issues and promotes the involvement of teenagers in programs for younger students. Whenever possible, drug-related topics are integrated into other subject areas. Representative impressions elicited from students indicate that they want a voice in school decision making; they learn best when material is related to their concerns; they desire responsibility; they want an avenue for their grievances; they oppose permissiveness; and they want to work for change.

81-1754
Straight Talk About Drug Education.
Folkers, F. G.
Curriculum Review 19(2):126-128, April 1980.

Although students demonstrate a superficial sophistication about drugs and drug use, most students have little specific knowledge about drugs. Few students possess the broad base of accurate knowledge needed to assess risks, determine consequences, and make decisions. In addition to providing information about drugs, drug education programs must help students develop self-awareness, positive feelings about themselves, and communication and decision-making skills. In a classroom environment where closely controlled behavior is emphasized, the atmosphere of open communication necessary to effective drug education is lacking. Inservice workshops to prepare teachers for drug education courses should provide overviews of the drug abuse problem and of the curriculum guide to be used, dramatizations or videotapes of possible learning activities, instruction in role-playing techniques, readings or lectures on pharmacology, and legal and psychological aspects of drug use. Finally, community involvement must be encouraged to involve parents, gain financial support, and reach adolescent abusers.

81-1755
School-Based Instruction for Improving Oral Health: Closing the Knowledge Gap.
Frazier, P. J.
International Dental Journal (The Hague) 30(3):257-268, September 1980.

Educational priorities in school programs should be consistent with scientific knowledge about the effectiveness and efficiency of all preventive strategies, including the use of fluorides, moderation in the consumption of highly sugared snack foods, plaque removal, early and periodic dental care, and all combinations of these measures. Students should be taught not only measures that the individual can adopt, but also the means by which the individual can contribute to the oral health of the community, such as by initiating and supporting water fluoridation or supervised self-applied fluoride programs. The challenge for education is to close the gap between scientific knowledge and the information and services made available to students, school personnel, community leaders, and the public. A comprehensive school dental program should include proven preventive services, routine dental care at school or an efficient system of referral and followup, and a comprehensive oral health curriculum for all grade levels. Numerous references.

81-1756
Teaching Vocabulary and Developing Concepts in Health.
Grubaugh, S. and Molesworth, R., Jr.
Journal of Reading 23(5):420-423, February 1980.

The language of health education was carefully controlled to teach junior high school students at Bill Reed Junior High School in Loveland, Colorado, to relate evaluative terms to concrete items in order for students to establish values on health issues. The major goals of two units were to have students redefine words which are often taken for granted and to develop concepts concerning value-related words. Students were asked not to give dictionary definitions for words like "cigarette" and "nicotine" but to write definitions in their own words and phrases, using only information derived from the five senses. Each word was explained, demonstrated, or defined before any health-associated meanings were introduced. Students were taught that words were not being considered separately; learning the relationships between the words was the basis for the health unit. Filmstrips, films, class discussions, lectures, pamphlets, and demonstrations were provided in each class, with time set aside for word redefinition. A spaced review strategy allowed brief reviews of the definitions over a 2-month period. The final evaluation revealed that students understood and retained words and concepts from the unit. The teaching method was intended to promote student awareness, provide health facts, and provide a method of weighing health issues according to personal values.

81-1757
Health Awareness Built Into Health Service Delivery in a Community College.
Heilig, M. C.
Journal of the American College Health Association 26(2):98-101, October 1977.

The health center of Delaware County Community College (DCCC) in Media, Pennsylvania, implemented a pri-

mary nursing care and health awareness program in which a nurse serves as health educator and community outreach program coordinator. To be an effective educator, the nurse must make every visit to the center a learning experience, initiate promotional campaigns about the center's services, and develop community outreach programs. DCCC programs include (1) Blood Pressure Day, a day-long blood pressure screening program that uses volunteer screeners stationed around the campus; (2) Slim-Lines, a 10-week weight control program that uses health information handouts, food intake diaries, and weekly weight measurements; and (3) Fan-Out, which offers informal student discussion groups. The student government association has been particularly helpful in underwriting expenses for screening efforts and discussion groups. The center also maintains liaisons with all college departments to ensure the efficacy of its outreach efforts. 3 references.

81-1758
The "Five Food Groups" in Nutrition Education.
Hewett, A.; Scown, H.; Watkinson, D.; and Smith, B.
Food and Nutrition Notes and Reviews (Canberra) 37(2):56-57, 1980.

To clarify the use of the five food groups in nutrition education, the benefits and limitations of the approach are presented. A survey of 18 schools in the Adelaide, Australia, metropolitan area indicated that, although many home economics teachers used the "five food" categories approach in junior high schools, their general nutrition understanding was inadequate. The teachers were unclear about the rationale for the five food-group categories and did not understand the importance of quantifying desirable amounts for daily consumption. Use of such a technique can facilitate nutrition education by expressing the daily diet in familiar terms, recommending the number of group servings required to fulfill the recommended daily allowance, and providing practical criteria for students to evaluate the quantity and quality of the food they eat. Limitations include inadequacy to (1) correct specific nutritional problems such as high fat or salt consumption; (2) classify many processed foods and fast foods in the groupings; (3) meet dietary requirements of individuals with special nutritional needs; and (4) indicate a hierarchy of importance. Suggested classroom uses of the five food approach are presented. 2 references.

81-1759
Cardiovascular Fitness Education for Elementary Students.
Jenkins, D.
Journal of Physical Education and Recreation 49(5):59, May 1978.

A cardiovascular fitness education program should help children understand the physical effects of exercise. Cardiovascular fitness activities have been designed for grades 1 through 6 at the Glen School in Ridgewood, New Jersey, with special emphasis on grades 5 and 6. The program consists of (1) classes to discuss and experiment with exercise; (2) discussion about exercise effects during regular physical activity sessions; (3) cardiovascular warmup exercises; and (4) cardiovascular fitness evaluations at the beginning and end of the school year. An outline by grade level showing the kinds of activities that promote children's understanding of cardiovascular fitness includes running; jogging; comparing heart rate after various physical activities; self-monitoring pulse rates and heart rate recovery time; achieving target heart rate; relating blood pressure to exercise; learning aerobic exercises; and distinguishing aerobics from anaerobics. The program provides sixth grade children with an understanding of the effects of various types of exercise on the cardiovascular system, simple exercise terminology, improved scores on cardiovascular fitness tests, and motivation to exercise.

81-1760
An Evaluation of Ombudsman Primary Prevention Program on Student Drug Abuse.
Kim, S.
Journal of Drug Education 11(1):27-36, 1981.

A study involving 185 students enrolled in grades 5-9 in 3 schools in Charlotte, North Carolina, was designed to assess the outcomes of the Ombudsman drug prevention program. The program is currently being disseminated nationwide via the National Diffusion Network of the U.S. Department of Education. The program involves students at all grade levels in a semester-long class that covers communication skills, decision-making abilities, and helping relationships. Program instructors work with teachers, guidance counselors, and school health personnel. The design involves a series of exercises in values clarification, followed by participation in group skills activities and then student implementation of a school or community project. The study population was divided into a control group and three intervention groups to allow assessment of various aspects of the program. An attitudinal inventory was administered to all students before and after programming. Data from the survey indicated that (1) students who had participated in the program had experienced significantly more positive attitude changes when compared with control students; (2) special Ombudsman instructors were perceived more positively than regular teachers; (3) the program was more effective for students whose regular teachers had undergone special inservice training than for other students; and (4) the program was more effective among elementary students than among other students. 6 references.

81-1761
The Primary Grades Health Curriculum Project.
Lynch, B. S.
(Atlanta, Ga.), Center for Disease Control, Bureau of Health Education (DHEW Publication No. (CDC)80-8382), 30 p., (198-).

The Primary Grades Health Curriculum Project resulted from cooperative efforts between the Bureau of Health Education and the American Lung Association. The project was developed as a companion project to the School Health Curriculum Project. The units were originally written and developed within the Seattle School District, then tested in four sites in different areas of the country. The units for each grade level are taught in a structural sequence of phases over 10 or 12 weeks. After an introduction designed to arouse curiosity, each unit provides opportunities for youngsters to overview the senses or a particular body system, develop an appreciation of that system, gain specific information about the structure and function of the system, develop an understanding of the system's diseases and problems, and consider and practice care of the body and prevention of disease. Children are involved in the learning process through use of life experiences, audiovisual and reading materials, resource people, and hands-on experiences. Teachers and school administrators are trained in implementation of the curriculum during 4- to 5-day workshops. A teaching team is composed of two teachers for each grade level, the principal, and one or two support personnel. The curriculum has had an evaluation component from the start, and a longitudinal study was begun in September 1977.

81-1762
Michigan Council on Physical Fitness and Health: Annual Report to the Michigan Department of Public Health, December 29, 1978.
Michigan State Dept. of Public Health, Lansing. Michigan Council on Physical Fitness and Health.
Lansing, Mich., the Council, 17 p., December 29, 1978.
Available from: ERIC; Order No. ED-167 510.

During 1978, the Michigan Council on Physical Fitness, an advisory council of the Michigan Department of Public Health, undertook several projects to promote physical fitness, model physical fitness and health programs, and identify the role of State and local governments in motivating and regulating physical fitness and health. The council also attempted to identify marketable techniques for maintaining physical fitness. A total of 334 schools from 76 districts participated in "Project Fitness-Phase I," which employed either the Michigan Association for Health, Physical Education, and Recreation Test Battery or the American Alliance for Health, Physical Education, and Recreation Youth Fitness Test Battery. In phase II of the project, which was endorsed by the health department in August 1978, schools will continue to monitor the fitness levels of students. A cardiovascular health program, entitled "Feelin' Good," conducted at the Northwest Middle School in Jackson, Michigan, provided 80 sixth- and seventh-grade students with healthy alternatives to snack food. The department also sponsors the daily physical education program in State schools and the Governor's Physical Fitness and Health Award in addition to numerous ancillary activities.

81-1763
The Student as a Catalyst for Change.
Neely, R.
Tucson, Ariz., Student Health Service, University of Arizona, 8 p., May 15, 1979.
Available from: ERIC; Order No. ED-175840.

The Student Health Promoter (SHP) program at the University of Arizona is a campus-based service offering students an opportunity to increase their awareness of wellness activities through the use of peer counseling techniques. SHP participants are undergraduate students, not necessarily enrolled in health education, who serve as referral counselors for both campus and community health agencies. The SHP training program is a three-credit course and offers curriculum areas relating to self-care, counseling skills, general knowledge of disease and treatments, general instruction in the pharmacology of nonprescription drugs, health risk assessment techniques, cardiopulmonary resuscitation and basic first aid, use of the university's health manual, and contraceptive information and education. Student progress during the training period is monitored by observation and performance indicators. Selection of trainees for the program is based on a combination of personal and academic qualifications.

81-1764
Tobacco Education Curriculum: Grade Two. Health Education: Substance Abuse Prevention.
New York State Education Dept., Albany. Bureau of Drug Education.
Albany, N.Y., the Department, 99 p., 1979.
Available from: ERIC; Order No. ED-180 984.

Guidelines for implementing a tobacco education curriculum for second grade students are offered for use by teachers and administrators. Each unit, designed to reinforce a major concept in regard to smoking, includes

learning activities and suggests instructional materials and resources available to the teacher. Concepts addressed include the value of a positive self-image in social interactions and decision-making processes, the relationship between a healthy body and adoption of antismoking attitudes, the importance of breathing in maintaining the body systems, the hazards of personal and environmental air pollution, and the formation of habits. Factsheets and worksheets are included. Appendices include addresses and phone numbers of the American Cancer Society's county unit offices in New York, State offices of the American Heart Association, and State affiliates of the American Lung Association.

81-1765
When the Student Is Ready, the Teacher Will Come: A Perspective on Health Education.
Owen, S. L.
Journal of the South Carolina Medical Association 76(9 Suppl.):16-20, September 1980.

The Georgia affiliate of the American Heart Association developed a heart health curriculum entitled "3 R's and HBP" (high blood pressure) after identifying high blood pressure as a major health problem in Georgia. Based on the premise that fifth and sixth grade students can be taught practical information relating to high blood pressure, the curriculum is designed to help teachers reinforce positive health choices made by students, provide students practical health information, and enable students to measure their own blood pressure. The program promotes small-group interaction and family dialogue to encourage children to accept responsibility for their health. The curriculum is open ended, allowing adaptation by teachers after they have been trained in regional workshops. The first 3 days of the curriculum deal with the circulatory system, high blood pressure, and coronary risk factors; the remaining 2 days involve applying practical skills. Thus far, several hundred thousand students in over 120 counties have received instruction by 700 trained teachers, and results have been so favorable that 29 other States are implementing similar programs. 11 references.

81-1766
Teaching the Kids: From Preschoolers to High Schoolers.
Serrano, T.
Food and Nutrition 9(6):16-17, December 1979.

Nutrition education at Nova High School in Redding, California, is conducted through an interdisciplinary curriculum that is integrated into science, mathematics, language, literature, and personal growth courses. Funded by the State Department of Education, the program began in 1976-77 with a weight-loss class that included nutrition workshops. During the following year, after-school nutrition workshops for teachers were added. The complete Nutrition Education and Training Program was instituted in 1979-80. Students in the weight-loss class have compiled a book of low-calorie snacks; a library of books, games, and films; visual aids for use in understanding food labeling; and their own videotaped food commercials. Workshops on food labeling, food advertising, snacking, and the basics of food and nutrition were offered to parents. Observations in classrooms and in the cafeteria have indicated that the program positively affects student behavior. The program coordinator maintains interest in the program by inviting media representatives to examine the program, holding semiannual meetings with teachers, encouraging nutrition displays, and publishing a newsletter for parents.

81-1767
The "Know Your Body" Program: A Developmental Approach to Health Education and Disease Prevention.
Williams, C. L.; Carter, B. J.; and Eng, A.
Preventive Medicine 9(3):371-383, May 1980.

The "Know Your Body" (KYB) school health education program combines health screening, a behavior-oriented health curriculum, and special interventions for high-risk students. The KYB curriculum is designed around health decision making in which health concepts are related to lifestyle through the development of both cognitive and behavioral skills. The KYB curriculum material is divided into 2 levels--elementary and junior high school--with the material divided into 10 units per level. The different teaching levels provide a progression of concepts, objectives, and activities, based on the child's maturity. Personal involvement and peer group norms are emphasized. Classroom activities extend into the home, family, and community setting. Feedback of health screening information in order to foster specific lifestyle behavior changes is an essential component of the personal approach. Evaluation of the curriculum, which includes measures for behaviors outside the classroom setting, has shown positive results. Sample health knowledge questionnaires and a health habits survey are appended. 11 references.

81-1768
Changing Oral Hygiene Attitudes and Habits.
Woolley, J. M.
International Dental Journal (The Hague) 30(3):249-256, September 1980.

Up to the time of the establishment of the Dental Health Education and Research Foundation in 1972, the practice of preventive dentistry was almost unknown in Australia. Children were given little dental health instruction in schools, and most parents were uninformed of the need to care for their own or their children's teeth. Now dental health educators are trained to instruct schoolchildren in such subjects as diet, oral hygiene, and plaque control. A Good Teeth Puppet Theater has been established, and a special preventive dentistry script has been written. A mobile dental health education unit, equipped with a room lit by ultraviolet light, an audiovisual instruction area, and a minilaboratory, is sent to various secondary schools. Pupils have been encouraged to use plaque-disclosing material, and descriptive films and personal dental health instruction are provided. More than 2.5 million children have participated in these programs. Evaluations of the school programs have revealed that after 6 months children were able to recall more than 70 percent of the dental health message. Results of a recent survey by the World Health Organization of the oral health of 13- and 14-year-olds in Canterbury, New Zealand, Sydney, Australia, Trondelag, Norway, Yamanashi, Japan, and Hanover, West Germany, showed that the children in Sydney, where the Dental Health Education and Research Foundation programs operated, had the lowest rate of dental caries. 3 references.

81-1769
"Hashish and Marijuana"--An Innovative, Interdisciplinary Drug Education Curricular Program for High Schools.
Zoller, U. and Weiss, S.
Journal of Drug Education 11(1):37-46, 1981.

"Hashish and Marijuana," an interdisciplinary curricular unit, is an attempt to cope with the drug abuse problem among adolescents through high school science classes. The unit was developed at Haifa University in Israel and has been field tested on a pilot scale. It is designed for integration into a chemistry course, which provides a factual basis around which the relevant aspects of biology, medicine, sociology, psychology, pharmacology, law, economics, and behavioral science are constructed. Active participation by students and integration of cognitive and affective spheres are central to programming. Preliminary results from field tests indicate significant, positive changes in the attitudes and cognitive levels of the target population. The curriculum was favorably accepted by both students and teachers. Based on these results, it is believed that the program is a viable educational vehicle for equipping high school students with the necessary intellectual background and attitudinal strength to cope successfully with the problem of drug abuse. 21 references.

SELF-CARE

81-1770
Teaching Personal Health Surveillance to Medical Students.
Baker, C.
Journal of Family Practice 10(5):904-906, May 1980.

Introduction of personal health surveillance concepts into the medical school curriculum is a primary means of fostering increased responsibility among physicians for their own as well as their families' health. In response to studies showing that physicians have poor personal health maintenance, the University of South Carolina School of Medicine provides instruction in various methods of health screening to medical students in their first year. Such students in the family practice residency at Richland Memorial Hospital in Columbia, South Carolina, are presented with an outline of the health maintenance program and asked to conduct a personal health surveillance inquiry on themselves and their families. Other medical schools may be able to improve the health of their graduates by incorporating similar programs into their curricula. The annual physical examination should be replaced by an annual health inquiry that includes an updating of family health data and a review of the physician's habits, psychosocial status, family status and function, work history, and emotional adjustment. Selected screening examinations and tests are also recommended according to the physician's age. 5 references.

81-1771
The Complete Book of Physical Fitness.
Fisher, A. G. and Conlee, R. K.
(Provo, Utah), Brigham Young University Press, 162 p., 1979.

Guidelines are provided for developing a comprehensive personal physical fitness program. Topics include guidelines for cardiovascular fitness; muscle strength; flexibility; exercise and weight control; exercise and the environment; family activity, aging, and myths about fitness; and sensible physical activities, required equipment, safety precautions and tests to monitor individual progress. Appendices include the nutritive value of common foods, the "basic four" foods, food exchange lists, and energy expenditure in various activities.

81-1772
Common Sense--Common Health Evaluation: Final Report and Executive Summary.
Kemper, D. W.
Boise, Idaho, Healthwise, Incorporated 76 p., March 31,

1979.
Available from: NTIS; Order No. PB80-184153.

A research study involving 1,930 individuals representing 483 families was undertaken in a fee-for-service clinic, a prepaid group practice, and four rural communities to evaluate the effectiveness of the Healthwise Workshop, a widely used self-care intervention program. A random selection generated control and experimental groups for the clinic and prepaid practice populations, while no control group was established in the rural settings. The workshop is a 10-week program with one 2-hour session held weekly. A physician, nurse, or nurse practitioner is designated as the major instructor. The sessions include lectures, presentations of videotapes, discussions, demonstrations, and a review of homework assignments. Session topics include home physical examinations, abdominal problems, backaches and headaches, respiratory problems, skin ailments, injuries, emergencies, dental care, nutrition, and development of a "healthwise" outlook. Evaluation involved use of a health knowledge questionnaire, interviews with workshop participants, use of various other evaluation instruments, examination of utilization data, and analysis of medical care costs. Analysis of data through computerized summaries and t-tests indicated that (1) clinic and referral costs in the prepaid group practice were 10 percent lower for workshop participants than for controls; (2) participants in the workshop from all settings demonstrated significant increases in self-care knowledge; (3) program enrollment was generally high; and (4) the workshops seemed to have little impact on the frequency of clinic visits.

81-1773
The Self-Help Component of Primary Health Care.
Robinson, D.
Social Science and Medicine. Medical Psychology and Medical Sociology (Oxford) 14A(5):415-421, October 1980.

An overview of various aspects of community participation in primary health care in developing and developed countries indicates that self-help programs must be implemented if health care is to be cost effective. Implementation of most preventive measures and health promotion and curative procedures does not require extensive professional training. In fact, medicine as practiced by the medical establishment is seen by many people as a means of diverting attention from the sociocultural and environmental causes of ill health. As a result, self-help groups have emerged to provide primary prevention assistance to groups of persons with mutual interests or problems. After organizing around a target problem, a self-help group shares information and techniques to deal with the problem, works to disperse the stigma associated with the shared problem, and then develops a network of relationships and activities within and outside the group that support the members. Self-help clubs independent of the medical establishment and those that maintain close liaisons with the establishment have proven effective in providing primary health care. Self-help groups can be integral to the activities of the International Conference of Primary Health Care toward realizing health for all by the year 2000. 14 references.

81-1774
Components of a Successful Home Dialysis Program.
Shurr, M. and Roy, C.
Nephrology Nurse 2(5):51-60, September-October 1980.

The home dialysis training program at the Veterans Administration-University of Iowa Hospital complex is described. The four basic components of the program include an initial introduction of the patient and family to the home training unit, formalized family meetings with the training staff before the start of home dialysis training, individualized training, and social and nursing participation in followup care. Patient-provider contracts are a key facet of the program. After hospital discharge, followup care is provided through regularly scheduled visits to the renal clinic, frequent telephone communication with the training staff, and an emergency telephone service on evenings and weekends. During the last 8 years, 42 percent of hemodialysis patients (223 people) participated in the training; of these, 73 percent completed the program and use home dialysis. The program is successful because of consistency of approach, commitment of staff to the concept of self-care, cooperation among dialysis team members, and clear assignment of responsibilities to team members and patients. 3 references.

SEX EDUCATION

81-1775
Human Sexuality--Sex Education. (A Position Statement Approved by the ASCA Governing Board, July 1979).
School Counselor 27(4):317, March 1980.

The American School Counselor Association (ASCA) proposes human sexuality education at levels that can be assimilated by students at various ages. It is important that

teaching and counseling personnel have an attitude of openness and understanding and a willingness to be honest with students. The ASCA supports parental and community cooperation in establishing developmental programs on human sexuality and encourages adequate training and certification for persons designated as teachers or facilitators of these programs.

81-1776
Teenage Pregnancy: The Best Argument for Sex Education.
Curriculum Review 19(2):130-131, April 1980.

Efforts by the University of Pittsburgh and the Philadelphia public school system to deal with problems associated with teenage pregnancy were discussed at a meeting in Kansas City, Missouri, of representatives of school systems, boards of education, health professions, and the National Parent-Teacher Association. The meeting was sponsored by the March of Dimes and the Association for Supervision and Curriculum Development. A pregnant teenager in Pittsburgh can remain in her own high school or transfer to the "Ed-Med" school, a combination school and childcare center run by the University of Pittsburgh with funding from the Pennsylvania State Department of Welfare. The city school system also has a policy assuring that State law regarding provision of confidential information on pregnancy or venereal disease is obeyed. The Philadelphia model includes a basic family living course that must be taken by all students, brochures on parenting and family living, and a series of elective courses that include family living components. An elective course in sex education for 11th- and 12th-graders is being developed. To ensure full community involvement, course participants will be required to obtain parental permission.

81-1777
Sex Q and A: Frank Answers to Your Most Delicate Patient-Counseling Questions.
DeMoya, D. and DeMoya, A.
RN 43(9):161-162, September 1980.

Nurses must provide direct answers to their patients who suffer from sexual dysfunctions such as postmenopausal painful intercourse, amenorrhea, honeymoon cystitis, and urethral fistula. Psychological and physiological factors must be considered in diagnosis; patients should be reassured about their sexual adequacy, and, when necessary, encouraged to participate in treatment. Two textbooks on human sexuality are recommended for nursing students: "Textbook of Human Sexuality for Nurses" and "Textbook of Sexual Medicine."

81-1778
Signs for Sexuality.
Doughten, S. D.; Minkin, M. B.; and Rosen, L. E.
Seattle, Wash., Planned Parenthood of Seattle-King County, 122 p., 1978.

Sign language for vocabulary commonly used in sexuality education is provided for use by teachers, counselors, interpreters, parents, and the hearing impaired. Photographs of the signs are compiled in a dictionary format, and each sign has a detailed description: hand shape, position, movement, and expression (if appropriate). The resource manual is intended for use by people knowledgeable in manual communication, not for the beginner of sign language. Materials appended include diagrams of the male and female reproductive systems; resource books; a selected bibliography relating to sexuality and deafness; a directory of producers of sexuality education materials; a directory of national organizations related to sexuality education; and a bibliography relating to sexuality education, curriculum development, and group management.

81-1779
Sexual Assertiveness Training for Adolescents.
Drake, L. W.; Nederlander, C.; and Mercier, R. G.
Journal of Current Adolescent Medicine 2(5):47-49, May 1980.

Sexual assertiveness training teaches adolescents to communicate about sex with adults and their peers. Adolescents are encouraged to understand their personal desires, physiological and psychological consequences of sexual participation, and means of achieving desired sexual goals. To ease and enhance sexual communication with peers, adolescents should be aware that any gathering offers the potential setting for interpersonal communication, that physical characteristics and impressions are important, that assertiveness and honesty are crucial to interpersonal relationships, and that responsible interpersonal caressing requires the assent of both sexual partners. Communication between adolescents and adults should be encouraged. In communicating with adolescents, adults must be responsive to and recognize the importance of the teenagers' situation, offer continuous feedback and refrain from becoming defensive, rephrase negative comments to accentuate positive features, and set clear rules for behavior. Adolescents should provide rewards for positive parenting behavior and rehearse new habits.

81-1780
Sex Education in the Public Schools: A Reexamination of the Issues.
Hess, F.; Martin, W. J.; Beck, J. D.; and Parker, D. C.
East Syracuse, N.Y., East Syracuse-Minoa Central Schools, 23 p., February 1979.
Available from: ERIC; Order No. ED-172 397.

While supporters of sex education curricula see their efforts as a means of coping with the side effects of the new morality, opponents argue that such courses infringe on both the right of the individual and the American tradition of dealing with sex in religious and family settings. On the local level, implementation of sex education curricula involves defining the limits of sex education, developing instructional methodologies and procedures to meet designated needs, appointing effective teachers, allocating financial support, and evaluating program effectiveness and cost effectiveness. Implementation of sex education programs is complicated by arguments about the moral nature of sex education, since there can be no teaching about sexual topics without moral overtones. Furthermore, the assumed remedial nature of sex education has yet to be empirically established. A suitable curriculum for sex education has not been written, and teacher training for sex education is inadequate. Yet, even if such a curriculum and well-trained teachers existed, the public schools are not now equipped to accommodate such a massive interdisciplinary program. Numerous references.

81-1781
The Betrayal of Youth. Part I.
Lorand, R. L.
NYSSNTA Journal 9(2):18-21, Winter 1977.

Important facts about the dangers of early and permissive sexual behavior are not included in school sexual education--facts which might cause reasonable adolescents to refrain from sexual activity. According to the author, responsible sexual behavior is often described to these children as proper use of contraceptives and visits to the clinic if symptoms of venereal disease appear. Medical evidence links early coitus and cervical cancer. Teenage girls often do not enjoy coitus and may participate because of peer pressure, insecurity, and the need to defy parental authority. Rather than distributing contraceptives, family planning agencies should be providing expert counseling to help children resist peer pressure and acquire a sense of worth from constructive activities. 1 reference.

81-1782
The Betrayal of Youth. Part II.
Lorand, R. L.
NYSSNTA journal 9(3):13-15, Spring 1978.

The Swedish sex education program, which emphasizes the use of contraceptives and the removal of sexual inhibitions, as well as the psychological and physiological concomitants of the program, were imported into the United States in 1964 with the support of planned parenthood, according to the author. Incidence of venereal disease in Sweden began to climb in 1954, the year compulsory sex education was enacted into law. Similarly, incidence of venereal disease in the United States reversed its downward trend in the mid-1960's. Mass education programs have unquestioningly accepted the promiscuity of adolescents. The incurable nature of genital herpes and cytomegalovirus, the penicillin-resistant strains of gonorrhea, and the relationship between early intercourse and cervical cancer are not discussed in educational campaigning. Fear tactics in sex education should not be discouraged when fear is an adequate response. Fear is a fundamental life-protecting response that can be used to reduce the incidence of venereal diseases and curb promiscuity.

81-1783
The Betrayal of Youth. Part III (Conclusion).
Lorand, R. L.
NYSSNTA Journal 9(4):29-35, Summer 1978.

The liberalization of sex education in Sweden in 1954 has been followed by increases in the number of divorces and illegitimate births and in other symptoms of instability among adolescents, according to the author. Despite the fact that two surveys made in the United States in 1965 revealed a lack of interest on the part of schools in having sex education courses as well as strong community opposition to them, the Federal Government provided 2 million dollars to encourage American schools to implement sex education programs based on the Swedish model. Numerous other tax-exempt organizations, such as the Planned Parenthood Federation of America, received financing for similar ventures. Planners of these efforts apparently disregarded Swedish studies that indicated a considerable amount of sterility in Sweden resulting from intrauterine device infections and venereal diseases. Contraceptive instruction cannot prevent pregnancies among adolescents who wish consciously or unconsciously to become pregnant in order to please or defy their parents, relieve depression, or fulfill some other psychological need. Intensive sex education that lacks moral components and easy access to family planning clinics are more likely to exacerbate than to solve problems associated with teenage sexuality. 17 references.

81-1784
Family Life Education: A Problem-Solving Curriculum for Adolescents (Ages 15-19).
Planned Parenthood Center of Memphis, Tenn.
Rockville, Md., Bureau of Community Health Services (DHHS, HSA) (DHHS Publication No. (HSA)80-5667), 179 p. (loose-leaf), 1980.
Available from: GPO.

Guidelines for implementing a family life education curriculum are provided for use with students 15 to 19 years old. The curriculum uses a problem-solving approach to the key issues in parenthood and family planning. Topics include the rationale for the curriculum, general objectives of the curriculum, curriculum format, effective use of the problem-solving approach, and curriculum activities. Curriculum activities allow for development of a positive concept of sexuality, development of a sexual identity, development of healthy relationships with parents and adults, development of a healthy relationship with peers, preparation for marriage and parenthood, and health issues in family life. The curriculum is aided by numerous films designed to stimulate classroom discussion. Appendices include a bibliography concerning family life in various cultures and discussions of growth and development at puberty, male and female anatomy and physiology, development tasks during adolescence, Erickson's developmental tasks, conflicts between adolescents and their parents, Maslow's theory of motivation and human needs, the teenage sexual revolution and the myth of abstinence in the past, teenage pregnancy, a couples study designed to determine factors involved in such partnerships, definition of love for adolescents, parenting decision values, sexually transmitted diseases, methods of family planning, fertility problems, and symptoms during pregnancy.

81-1785
Sex Education for the Mentally Retarded.
Russell, T. and Hardin, P.
Education and Training of the Mentally Retarded 15(4):312-314, December 1980.

Recent research has supported sex education as an important factor in the normalization within society of the mentally retarded and has indicated that sex education for this population should be provided by the schools rather than by parents. Research findings have indicated that (1) institutionalized retarded youth have less sexual knowledge than their noninstitutionalized peers, but the two groups have similar sexual attitudes and self-concepts; (2) the retarded have difficulty communicating with their parents about sexual matters but show a desire to learn about such subjects from other sources; (3) teachers, in general, have a favorable attitude toward sex education for the educable retarded, while parents are unwilling and often unable to educate their retarded children about sex; and (4) parents want their retarded children to learn about sexual topics and issues. Hence, it appears that the school is the best setting for sex education for the retarded. 15 references.

81-1786
Family Planning Education as an Integral Part of Day Care Services in Korea.
Sung, K.
Studies in Family Planning 9(4):71-74, April 1978.

In an effort to improve family planning and nutritional practices of low-income families, the services of many government-sponsored day-care centers in the Republic of Korea have been expanded to include family planning and nutrition classes for mothers. The Integrated Day Care Program, which began as a nutrition program run by CARE in 300 health centers, is being expanded into more of the estimated 1,414 centers throughout the country. The program provides daily meals for children at the centers 6 days a week, monthly classes in family planning and nutrition for mothers, and free contraceptives. Special attention is focused on rural-urban migrants and other mothers with high fertility rates and low birth-control-practice rates. The Korean Institute of Family Planning trains center nutrition instructors in family planning education and counseling techniques. Program data were compared from 30 participating and 15 nonparticipating centers, and interviews were conducted with 1,029 mothers from the 30 centers participating in the program and 459 mothers from the 15 nonparticipating programs. Results of the evaluation indicate that the program was generally accepted by mothers and that program mothers had higher levels of family planning knowledge, more favorable attitudes toward family planning, and higher levels of contraceptive practice than nonprogram mothers. The program is consistent with government policy and can expand using existing facilities and personnel. 7 references.

81-1787
Sexual Information: Birthright of the Child.
Van Stolk, M.
Childhood Education 56(4):194-201, February-March 1980.

Sex education should begin in kindergarten and continue through graduate school. Many North American adults have not learned to accept sexuality because they were not taught emotional contact in infancy and childhood but

were trained instead to fear interdependence and to accept emotional isolation as the norm. Cultural taboos against physical and emotional satisfaction, the sexual abuse of children, family violence, youth crime, and homosexuality are related to the effects of sexual repression. The lack of publicly available information about the sexual and emotional aspects of human behavior contributes to the high level of stress. The role of the family in the development of children's sexual maturity and their subsequent adult adjustment should be acknowledged. Medical students should receive routine training for sex education in medical schools. Parents must have adequate knowledge not only of sexual matters but also of child-rearing practices that will enable children to develop their intellectual, emotional, sexual, and spiritual potential. 82 references.

81-1788
Program Evaluation in Sex Education: Outcome Assessment of Sexual Awareness Weekend.
Voss, J. R. and McKillip, J.
Archives of Sexual Behavior 8(6):507-522, November 1979.

A study of sixty-four 18- to 51-year-old college students and area residents in any of three weekend sexuality awareness workshops was undertaken to assess the outcome of a growth-oriented sex education program. The outreach program, which is offered for students on the Southern Illinois University campus, includes small and large group discussions; sexually explicit films; and a number of desensitization, sensuality, and communication exercises. A sufficient number of persons registered for the third workshop to permit formation of a control group. Evaluation of the workshop program was accomplished by a combination of experimental and quasi-experimental design techniques that were designed to overcome flaws of existing sex education research by explicitly delineating goals. A sex questionnaire, covering sexual knowledge, attitudes, and behavior, was administered to the participants of the workshops at the time of registration and 1 month later. Evaluation data supported workshop effectiveness in meeting program goals in the areas of attitude and behavior change, but not in the area of sexual knowledge improvement. It appears that the sexual growth experience provided by the workshop is particularly relevant to or biased toward upper class and religiously liberal participants who possess above average information on sexuality. A longer followup period and inclusion of various assessment techniques to supplement the self-report questionnaire currently used would improve the evaluation efforts. 29 references.

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Reproductive Health, Family Planning, and Venereal Disease Education: A Tool for Curriculum Development.
Washtenaw County League for Planned Parenthood, Ann Arbor, Mich.
Ann Arbor, Mich., the League. 26 p., 1978.

Curriculum guidelines for reproductive health, family planning, and venereal disease were developed through the cooperative efforts of the Washtenaw County School District, parents, the Michigan State Department of Education, the Washtenaw County Health Department, colleges and universities, and Planned Parenthood's Education Committee. Mandated by Public Act 226, the guidelines address reproductive health, sex education, family planning, human sexuality, family life, venereal disease, fetal development, marital information, and genetic information. The curricula are offered in five stages--grades K-2, 3-4, 5-6, 7-8, and 9-12--appropriate to students' intellectual, physical, and emotional development. Educational objectives, which consider cognitive and affective learning, and behavioral factors are presented for each curriculum area. The Washtenaw County League for Planned Parenthood, through cooperative efforts with local colleges, universities, and the health department, is preparing an inservice training program so teachers may obtain special certification to teach reproductive health.

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